

The CAHPS® Improvement Guide

Practical Strategies for Improving the Patient Care Experience



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Introduction and Overview

Health plans and medical groups have become increasingly interested in quality of care data that they can use to spur and guide improvement efforts. One important source of such information is consumers and patients, who can report on their direct experiences with health care services. Reports that reveal how consumers perceive the quality of their care can offer useful information for evaluating and improving performance — particularly in areas where consumers or patients are the *only ones* who can accurately judge how well the health care organization is doing. The most widely used instrument for collecting reports and ratings of health care services from the consumer's perspective is the CAHPS® Health Plan Survey.

Purpose of this Guidebook

The extensive and growing use of CAHPS surveys to assess the quality of health plans and medical groups has created a demand for practical strategies that organizations can use to improve the aspects of performance measured by CAHPS. This Guidebook is designed to help meet this need by describing specific strategies for improving the experience of care. It is aimed at executives, managers, physicians, and other staff who are responsible for measuring performance and improving the quality of health care services. Over time, the Guidebook may be updated to include new improvement strategies and offer additional resources.

Development of this Guidebook was supported by the Centers for Medicare and Medicaid Services (CMS), but the quality improvement (QI) strategies described here are intended to help all health plans and medical groups, regardless of their patients' source of coverage.

A Quick Overview of CAHPS

In 1995, the federal Agency for Healthcare Research and Quality (AHRQ) initiated the CAHPS program to develop surveys that venture beyond the measurement of patient satisfaction to elicit *reports* from consumers and patients about their experiences with health care services. Over the past several years, CAHPS has evolved into a coordinated set of survey instruments and reports designed to measure and communicate information on important aspects of health care quality from the consumer's point of view.

This guidebook focuses on the first CAHPS product, the CAHPS Health Plan Survey, which has been in use nationwide since 1997. New CAHPS products include surveys for assessing the experiences of patients with behavioral health organizations. Surveys on patients' experiences with medical groups, hospitals, and individual providers are currently being developed and tested.

Overview of the CAHPS Health Plan Survey

The Health Plan Survey includes instruments for gathering information from adults about their experiences with care as well as instruments designed to allow parents or guardians to report on their children's experiences with care. These instruments can be used with all types of health insurance enrollees (Commercial, Medicaid, and Medicare) and across the full range of health care delivery systems, from fee-for-service to managed care plans. Health plans and other sponsors often add supplemental questions to these instruments to meet other information needs (for example, to collect data on the experiences of adults receiving mental health services)

or to comply with the National Committee for Quality Assurance's (NCQA) requirements for reporting CAHPS results as part of HEDIS (the Health Plan and Employer Data and Information Set). Versions of the CAHPS Health Plan Survey have been developed and validated in numerous languages, including Spanish.

According to the National CAHPS Benchmarking Database (NCBD), the CAHPS Health Plan Survey is now administered routinely to enrollees of health plans covering an estimated 125 million Americans. (See Table 1.)

Table 1. Total Number of Enrollees in Health Plans Participating in the CAHPS Health Plan Survey, 2001

Sector	Number of Enrollees
Commercial Health Plans	65,000,000
Medicaid Managed Care	13,000,000
Medicare Managed Care	7,000,000
Medicare Fee-For-Service	32,000,000
Department of Defense	8,000,000
Total	125,000,000

What Does the CAHPS Health Plan Survey Measure?

To facilitate the reporting of results, CAHPS survey questions are organized into several major groups, called composites. In the CAHPS Health Plan Survey, the composites summarize enrollees' experiences in the following three domains:

Table 2. Composites for Reports on Care

Domain	Composite
Access	Getting Needed Care Getting Care Quickly
Interpersonal Care	How Well Doctors Communicate Courteous and Helpful Office Staff
Plan Administrative Services	Customer Service Claims Processing ¹

The CAHPS Health Plan Survey also includes four items that ask respondents about their *overall ratings* of the care they have received.

Ratings of Care

Personal Doctor or Nurse	Specialist Seen Most Often
All Health Care	Health Plan

Appendix A lists the rating questions and all of the items included in each reporting composite for the core CAHPS Health Plan Survey,² as well as the supplemental items included in the "claims processing" category. The table also shows the response options associated with each item in the survey instrument.

¹ "Claims processing" is not technically a composite, but this category represents a set of measures collected by nearly all health plans for HEDIS reporting (i.e., supplemental measures required for those plans reporting CAHPS 3.0H).

² The core survey is the instrument intended for use with adults enrolled in commercial managed care plans.

Why Is It Important to Improve CAHPS Scores?

The CAHPS surveys and reports are based on extensive research to learn what really matters to health care consumers. If a health plan scores poorly on CAHPS measures, it is not doing well in selected areas that are important to consumers.

Poor performance can have serious ramifications for health plans and providers. In a national study of Medicare managed care plans, Medicare beneficiaries' overall ratings of their health plans were significantly related to voluntary disenrollment rates ($r=-0.55$) (Terry et al. 2003). The mean voluntary disenrollment rate was four times higher for plans in the lowest 10 percent of overall plan ratings as measured by the CAHPS Health Plan Survey than for plans in the highest 10 percent of overall CAHPS ratings. This is an important finding, especially considering the fact that the CAHPS ratings were obtained by surveying current enrollees and did not include any enrollees who had already exited from their plan. Other studies have shown that poor scores on consumer surveys are related to trust in doctors and the intention to switch doctor and plan (Keating et al. 2002).

CAHPS survey measures also are associated with other aspects of care. For example, CAHPS scores have been shown to be significantly associated with several HEDIS measures of clinical care. A study of patients hospitalized for a heart attack in New Hampshire showed that patients with more positive reports about their care experiences had better health outcomes a year after discharge (Fremont et al. 2001). This study does not prove that poor interpersonal care necessarily results in worse outcomes, but it does indicate that an organization with poor patient reports has problems that affect outcomes.

The cost implications of these types of associations have not been rigorously assessed, but it is likely that the costs associated with poor patient-centered care are substantial.

To Learn More About CAHPS

For more information about the CAHPS program and products, please visit www.cahps-sun.org, a Web site maintained by the CAHPS Survey Users Network (SUN). If you register with the SUN, this site will allow you to download a free copy of the **CAHPS Health Plan Survey and Reporting Kit**, which includes the survey instruments, technical instructions, and recommendations related to reporting results of the Health Plan Survey. The site also offers guidance related to planning, managing, and evaluating a CAHPS project.

Who Collects and Reports Results of the CAHPS Health Plan Survey?

Sponsors of the CAHPS Health Plan Survey include government purchasers, private organizations (including employers), and health plans.

CMS as a Major Sponsor

The Centers for Medicare and Medicaid Services (CMS) is a major sponsor of the CAHPS Health Plan Survey. Since 1998, it has collected CAHPS data from members of all Medicare HMOs (also known as Medicare+Choice Organizations) in order to assess their experiences; it has collected data from beneficiaries in the traditional Medicare program since 2001. These results are shared with the health plans as well as with beneficiaries, who are encouraged to use the information to help choose the plan that best meets their needs. (See results available to the public at www.medicare.gov.)

In addition to reporting the results to the public, CMS is increasingly using data from Medicare Managed Care CAHPS in its quality assessment and improvement initiatives:

- /// The Medicare Managed Care Performance Assessment (PA) Project
- /// The Quality Assessment and Performance Improvement (QAPI) Program

This guidebook offers practical information that should be helpful for these initiatives.

The Medicare Managed Care Performance Assessment (PA) Project

The Medicare Managed Care Performance Assessment (PA) project represents an effort to move away from solely examining an organization's structure and processes and better assess the overall performance of Medicare managed care contractors. It also provides Medicare+Choice Organizations (M+COs) with more powerful tools for improving their performance.

The PA project reports present comparative data from multiple performance measure sets including, but not limited to, HEDIS, HOS (the Medicare Health Outcomes Survey), and CAHPS. It also includes certain financial measures used by State regulators that oversee the financial well-being of managed care organizations.. These reports help CMS staff assess the performance of Medicare managed care plans and assist the M+COs in monitoring and improving their own performance.

The Quality Assessment and Performance Improvement (QAPI) Program

The purpose of this program is to help Medicare managed care plans conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable improvement (defined as "significant improvement sustained over time") in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. CMS standards expect that an organization will:

- /// Continuously monitor its own performance on a variety of dimensions of care and services for enrollees,
- /// Identify its own areas for potential improvement,
- /// Carry out individual projects to undertake system interventions to improve care, and
- /// Monitor the effectiveness of those interventions.

Past QAPI projects have used CAHPS data to measure plan performance and improvement over time.

Other Sponsors and Users of CAHPS Data

Other sponsors and users include:

- /// **States:** Over half of all state Medicaid programs are now using the CAHPS Health Plan Survey to monitor the performance of managed care plans and primary care coordination programs serving enrollees in Medicaid and State Children Health Insurance Programs (SCHIP). Some release the information in public reports.
- /// **The Department of Defense:** The Department of Defense administers the CAHPS Health Plan Survey to evaluate the performance of its TRICARE health benefit plans.
- /// **Public and private employers:** A growing number of private and public employers, including the US Office of Personnel Management, use results of the CAHPS Health Plan Survey to make contracting decisions and to facilitate consumer choice of plans.
- /// **NCQA:** The National Committee for Quality Assurance (NCQA) in Washington, DC, requires CAHPS data from health plans seeking accreditation or participating in the public reporting of HEDIS.

Who's Responsible for Results of the CAHPS Health Plan Survey?

While the CAHPS Health Plan Survey is administered at the health-plan level, the results cover the performance of both the health plan and the medical groups that care for the health plan's enrollees. That is, some items in the CAHPS Health Plan Survey pertain to functions performed at the plan level (e.g., administrative services), while others address experiences at the level of care delivery (e.g., doctor communications). Consequently, before you can determine how to improve performance, it is important to distinguish who is accountable for the various aspects of performance being measured. The following table summarizes responsibility at the composite level.

Table 3. Who Is Accountable for CAHPS Performance?

While the locus of accountability will vary by organization, this table identifies which CAHPS domains and composites are associated primarily with the health plan and which are associated primarily with the provider network. For some aspects of care measured by the CAHPS Health Plan Survey, accountability for performance rests with both the plan and the provider network. The interventions and improvement strategies presented in the fourth section of this Guide are identified as the responsibility of either the plan, provider group, or both.

Reports on Care			
Who Is Accountable?			
Domain	Composite	Health Plan	Provider Network
Access	Getting Needed Care	✓	✓
	Getting Care Quickly		✓
Interpersonal Care	How Well Doctors Communicate		✓
	Courteous and Helpful Office Staff		✓
Plan Administrative Services	Customer Service	✓	
	Claims Processing	✓	

Ratings of Care			
	Personal Doctor or Nurse		✓
	Specialist Seen Most Often		✓
	All Health Care	✓	✓
	Health Plan	✓	

In those cases where accountability for CAHPS reports and ratings lies with the provider network, it is important to recognize that health plans still play a major role because they can influence the performance of medical groups through incentive programs and educational interventions designed to change provider behavior. Health plans can also develop systems for medical groups that help them deliver care more effectively and efficiently.

A Guide to the Guidebook

As illustrated on the following page, the Guidebook is organized into four sections:

- /// **Section 1** reviews five behaviors common to health care organizations that have been effective in improving their CAHPS-related performance.
- /// **Section 2** discusses ways to analyze data from the CAHPS Health Plan Survey in order to identify opportunities to improve experience with care.
- /// **Section 3** walks through the basic steps of a CAHPS-related quality improvement process.
- /// **Section 4** presents nearly 20 strategies that health care organizations can implement in order to help improve consumers' and patients' experiences with care. Some strategies are more appropriate for health plans, while others are intended for medical groups. But nearly all require some level of cooperation among plans and the providers in their network.

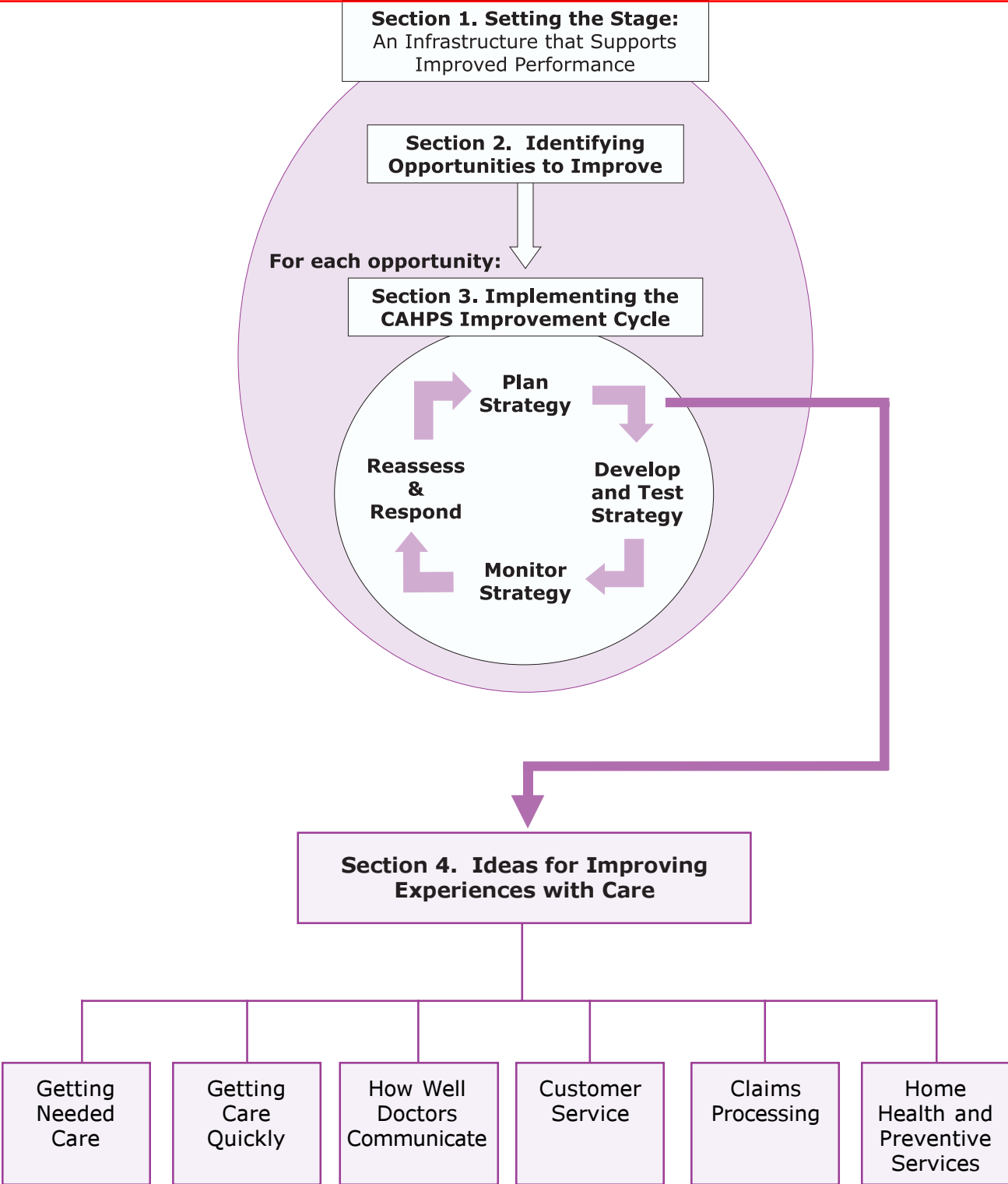
The strategies address each of the CAHPS reporting composites (including claims processing), as well as supplemental items related to home health and preventive care services for Medicare beneficiaries. To help you find the most pertinent ideas, a table at the beginning of this section shows which strategies you can use to address specific problem areas (by category and by measure). This table also indicates whether health plans or medical groups (or both) would be accountable for the problem area, and therefore responsible for implementing the strategy.

The summaries of each strategy cover the following questions:

- What is the problem that is shaping the patient's or member's experience with the health care organization?
- What is the practice that can help address this problem? What is its purpose? What benefits does it offer to patients, providers, and plans? How has it been implemented?
- What are the published results of an evaluation (if any)?
- What are some key resources for more information on the strategy?

In addition, at the end of this guidebook, there is a complete bibliography with additional citations and resources related to the quality improvement initiatives.

A Guide to the Guidebook



Section 1. Setting the Stage for Improved CAHPS Performance

Improving CAHPS scores often requires new tools and may challenge existing practices in your organization. It also takes time to work through the quality improvement (QI) process, i.e., to identify weaknesses, develop and apply solutions, and refine your strategies until they have a measurable and sustainable impact. Because of these challenges, it can be useful to start by assessing whether your organization operates in a manner that is associated with the successful implementation of CAHPS-related QI programs.

This section briefly reviews five behaviors common among organizations that are committed to improving their performance:

1. Focusing on microsystems (“where the action is”)
2. Cultivating and supporting QI leaders
3. Training staff in QI concepts and techniques
4. Paying attention to customer service
5. Recognizing and rewarding success

Once they become part of the organization’s culture, these behaviors often play a large role in supporting and driving successful efforts to improve members’ and patients’ experiences with health care. If any are missing or inadequate in your organization, you may want to think about ways to introduce them. At the very least, recognize the impact of their absence on efforts to improve CAHPS performance and plan accordingly. You may, for example, need to devote resources to training team members in basic statistical techniques, or set aside time to educate and build support among physicians or board members.

To help you learn more about these issues, a list of Key Resources is provided at the end of this section.

Focusing on Microsystems (“Where the Action Is”)

One way for health plans and medical groups to strengthen their QI programs is to think of the organization as a system, or more specifically, as a collection of interrelated “microsystems.” The term “microsystems” refers to the multiple small units of caregivers, administrators, and other staff who produce the “products” of health care – i.e., who deliver care and services on a daily basis. A unit could be a team of primary care providers, a group of lab technicians, or the staff of a call center.

The concept of microsystems in health care organizations stems from research findings indicating that the most successful of the large service corporations maintain a strong focus on the small, functional front-line units who carry out the core activities that involve interaction with customers (Quinn 1992; Quinn, Baruch et al. 1997). Adapting that organizational theory to the health care setting, health services researchers suggest that a microsystem would consist of the following elements (Nelson and Batalden 1999; Berwick 2002):

- /// A core team of health professionals
- /// A defined population of people or patients for whom they provide care
- /// An information environment to support actions of caregivers and patients
- /// Support staff, equipment, and office environment

These elements work together to perform related clusters of tasks. For a health plan, such tasks could include:

- /// Enrollment of members
- /// Disenrollment
- /// Claims processing
- /// Member services
- /// Supporting tasks (e.g., gaining knowledge of patients and populations; measurement of health, health status, and costs of care; measurement of microsystem performance)

For a medical group, tasks could include:

- /// Assignment of a person to a caregiver
- /// Orientation to the practice and its services
- /// First visit, initial assessment, and care planning
- /// Delivery of health care services: acute, chronic, and preventive

The goal of the microsystem approach is to foster an emphasis on small, replicable, functional service systems that enable front-line staff to provide efficient, excellent clinical and patient-centered care to patients (Nelson and Batalden 1999). To develop and refine such systems, health care organizations start by defining the smallest measurable cluster of activities. Once the microsystems have been identified, a practice or plan can select the best teams and/or microsystem sites to test and implement new ideas for improving work processes, and can then roll out effective changes to the broader organization over time. (Please see Section 3 for more on the role of microsystems in the CAHPS improvement cycle.)

Microsystems: The multiple small units of caregivers, administrators, and other staff who produce the “products” of health care.

For more information about microsystems in health care settings, please see www.clinicalsystems.org.

Also see: Wasson J, Godfrey M, Nelson E, Mohr J, Batalden P. Microsystems in Health Care: Part 4. Planning Patient-Centered Care, *Joint Commission Journal on Quality and Safety*, May 2003, 29(5).

Cultivating and Supporting QI Leaders

Many health care organizations are highly resistant to change. Employees are not encouraged to solve problems on their own, nor do they challenge the status quo. Most are accustomed to following standard operating procedures even when the policies and procedures may seem ineffective and outdated. Given the life and death issues confronted every day in most health care organizations, this risk-averse behavior is neither surprising nor hard to understand.

Because of this pervasive attitude, the search for better solutions and creative new approaches to long-standing problems requires strong and consistent encouragement and support. In order to achieve the goals of better performance on CAHPS measures, it can be useful for health plans and provider networks to cultivate strong leaders throughout their organizations. Leaders are those who can communicate a compelling vision, motivate clinicians and other staff to lower their resistance to change, and effectively and willingly participate in the redesign of new systems of care. Ideally, all levels of staff in the organization should become adept at leading change, making changes, and managing change.

Sources of Leadership

Leadership for quality improvement can emanate from multiple sources: the board, the CEO and senior leadership team, and mid-level managers. Leaders may obtain their power from the authority of a title, through mastery of knowledge, or through the strength of personality or persuasive abilities.

Senior Leadership: Studies suggest that leadership from the top is a key factor in determining whether clinicians and others support and participate in QI efforts (Weiner, Shortell et al. 1997). Senior leaders set the tone and establish the policies and organizational structure that can either strengthen or undermine QI efforts.

Mid-level Management: Because the CAHPS Health Plan Survey asks about processes of care at both the plan and medical group level, the success of efforts to improve CAHPS scores often depends on the involvement, or at least cooperation, of clinicians and medical group staff. Medical group physicians and mid-level managers can also encourage cross-functional improvements in a group practice or ambulatory care site by selecting interdisciplinary team members and physicians with a special interest in QI.

The Board: Finally, strong board leadership can play a crucial role in QI. With the high turnover rates in plan and medical group senior executives, the board can help sustain a corporate culture focused on quality and provide “constancy of purpose” (Weiner, Shortell et al. 1997).

Key Tasks for Leaders at Every Level

Those who study effective leadership have identified ten practices that leaders at all levels can implement to produce and maintain an environment that emphasizes and encourages quality improvement (Langley, Nolan et al. 1996):

1. Link QI goals to the organization’s mission and strategic plan (in other words, integrate improvement planning with business planning).
2. Establish and communicate the purpose of the organization.
3. Adopt and encourage a view of the organization as a system (see the discussion of microsystems on Page 10).

Attributes of Service-Oriented Leaders

Effective leaders maintain a focus on the needs of those they serve and their employees. Such leaders exhibit many of the following characteristics:

Energetic, creative	Not...	Stately, conservative
Participatory, caring	Not...	Removed and elitist
Listening, coaching and teaching	Not...	Supervising and managing by command and control methods
Motivating by mission	Not...	Motivating by fear
Leading by means of personally demonstrated values	Not...	Relying on institutional policies that are meaningless or outdated

Source: Heskett JL, Jones TO, Loveman G, Sasser EW, Schlesinger L, “Putting the Service-Profit Chain to Work.” *Harvard Business Review*. March-April 1994, 164-174.

- 4. Use measurement and management’s attention to keep the organization focused on the goals of QI efforts.
- 5. Allocate financial and other resources (e.g., staff) to QI endeavors.
- 6. Align incentives and performance appraisals to stimulate QI (i.e., create reward and recognition programs that reinforce the values and goals of the organization; see page 10).
- 7. Design and manage a system for gathering improvement information.
- 8. Remove barriers, which could be a function of finances, policies, system failures, internal politics, unsuitable attitudes, or legitimate concerns of personnel.
- 9. Become directly involved in continuous improvement projects, perhaps by managing individual and team improvement activities.
- 10. Market and advertise the QI work to the board, staff, and community through interpersonal communication, newsletters, and the media.

While some of these activities may be more appropriate for senior leaders, most can be applied throughout the health care organization.

Training Staff in QI Concepts and Techniques

One requirement for successful QI initiatives is a staff that is familiar with the reasoning that underlies these efforts and comfortable using the required tools and techniques. Many resources and educational programs are available to help organizations accomplish this. Here is a quick review of the kind of investment in training that you might want to make as you lead your health care organization down the path described in this Guidebook. At the end, you will find a list of pertinent readings and other resources.

Since training programs should address the “why” of QI as well as the “what” and the “how”, you may want to start by educating clinical and administrative staff on the central precepts of QI and how it can benefit the organization and its members/patients. It can be especially useful to share information on how others have used this approach to improve patients’ experiences with care and what their responses have been. For example, in a recent survey of physicians,

over three-quarters of those who had been affected by patient satisfaction surveys reported that the impact on the quality and efficiency of their practice has been positive (Haas, Cook et al. 2000; Reed, Devers et al. 2003). Strategies to improve patient satisfaction and involvement can also have an important effect on clinical outcomes and physician satisfaction (see box at right).

Once assigned to CAHPS-related QI teams, staff members will need basic training in specific QI concepts (such as microsystems, change concepts, small tests of change, and the diffusion of innovation) and methods. (Section 3 of this Guidebook discusses several of these concepts and methods in the context of the improvement cycle.) Depending on their role in the team, many staff will also benefit from more advanced training in the effective use of statistical methods, graphic analysis, and multidisciplinary teams. Teams that have had basic training in QI techniques and group work or team building are usually able to achieve success much faster than teams that have had no previous training or experience. However, sometimes teams focus on the training as the “end goal,” making it important to set clear aims for the success of any QI project at the outset.

It is important to note that physicians are unlikely to be familiar with QI methods. While many professionals and managers receive some kind of QI training in their basic education, most physicians do not. Doctors are trained to succeed as individuals but not as members of a team despite the reality that almost everything they aspire to accomplish is dependent on successful relationships with other staff and their patients.

Example of Impact of Improving Patient Satisfaction and Involvement

In the 1980's, Greenfield and Kaplan (Greenfield, Kaplan et al. 1985) designed a randomized controlled trial to assess the impact of increased patient involvement in care. The patients were visiting a clinic that specialized in ulcer disease.

During a 20-minute session before their regularly scheduled visit, patients in the experimental group received help in reading their medical record and were coached to ask questions and negotiate medical decisions with their physicians. The intervention relied on a treatment algorithm as a guide. Patients in the control group received a standard educational session of equal length.

Six to eight weeks after the trial, patients in the experimental group reported fewer limitations in physical and role-related activities, preferred a more active role in medical decision-making, and were as satisfied with their care as the control group. Analysis of audiotapes of physician-patient interactions showed that patients in the experimental group were twice as effective as control patients in obtaining information from physicians.

Results of the intervention included the following:

- ⚡ Increased involvement in the interaction with the physician
- ⚡ Fewer limitations imposed by the disease on patients' functional ability
- ⚡ Increased preference for active involvement in medical decision-making
- ⚡ Improved patient and physician satisfaction with the encounter

“Nothing about medical school prepares a physician to take a leadership role with regard to changes in the system of care.”

(Berwick and Nolan 1998)

Useful Resources on Training

Organizations that Offer Training and Related Resources:

American Association of Health Plans (AAHP)

1129 20th Street, NW
Suite 600
Washington, DC 20036
Phone: (202) 778-3200
Fax: (202) 331-7487
www.aahp.org

American Medical Group Association (AMGA)

1422 Duke Street
Alexandria, VA 22314-3430
Phone: (703) 838-0033
Fax: (703) 548-1890
www.amga.org

American Society for Quality

600 North Plankinton Avenue
Milwaukee, WI 53203
www.asq.org

Baldrige National Quality Program

National Institute of Standards and Technology (NIST)
100 Bureau Drive Stop 1020
Gaithersburg, MD 20899-1020
Phone: (301) 975-2036
Fax: (301) 948-3716
www.quality.nist.gov

Institute for Clinical Systems Improvement (ICSI)

8009 34th Avenue South
Suite 1200
Bloomington, MN 55425
Phone: (952) 814-7060
Fax: (952) 858-9675
www.icsi.org

The Institute for Healthcare Improvement (IHI)

275 Longwood Avenue, 4th Floor
Boston, MA 02215
Phone: (617) 754-4800
www.ihl.org

Medical Group Management Association (MGMA)

104 Inverness Terrace East
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National Committee for Quality Assurance (NCQA)

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Suite 500
Washington, DC 20036
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Fax: (202) 955-3599
www.ncqa.org

General Resources on the Rationale for a QI Approach:

Berwick, DM. Continuous Improvement as an Ideal in Health Care, *New England Journal of Medicine* 320:53-56 Jan 5, 1989.

Berwick DM. Video of 2001 IHI Forum Plenary Presentation, "Every Single One" (popularly known as Dr. Old Way/Dr. New Way"), December, 2001. www.ihl.org/resources/videos/index.asp.

Berwick, DM, A Primer on Leading the Improvement of Systems. *British Medical Journal* 1996; 312: 619-622.

Millenson ML. *Demanding Medical Excellence: Doctors and Accountability in the Information Age*. Chicago, Illinois: University of Chicago Press, 1997.

Other Useful Resources:

www.ImprovingYourMedicalCare.org

The Memory Jogger Series, A Pocket Guide of Tools for Continuous Improvement and Effective Planning, published by Goal QPC. These pocket guides are designed for use on the job and provide information about basic quality improvement tools, management, and planning tools.

Paying Attention to Customer Service

The ability of health plans and medical groups to deliver high-quality clinical and administrative service to their members and patients depends in part on their understanding of basic customer service principles and their ability to integrate these principles into clinical settings. This section briefly reviews why excellent service is so critical and suggests some steps for achieving better service at the physician, group, and plan level.

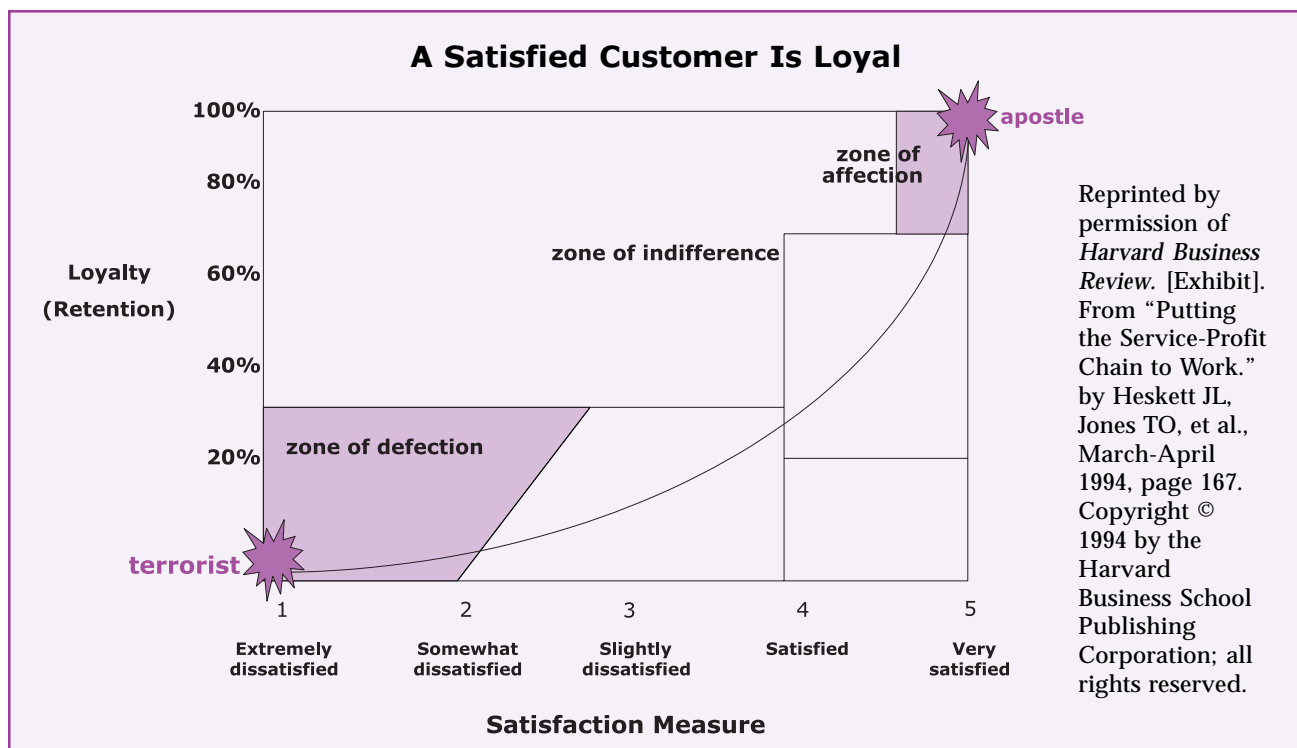
Excellence is an art won by training and habituation. We are what we repeatedly do. Excellence, then, is not an act, but a habit.

— Aristotle

Why Worry About Customer Service?

There are several reasons for health care organizations to pay attention to customer service:

- ⚡ First, better service translates into higher satisfaction for the patient – and subsequently, for the employer who pays most of the bills.
- ⚡ Second, as in any other service industry, a satisfied (and loyal) member or patient creates value over the course of a lifetime. In the context of health care, this value may manifest itself in the form of repeat visits, trusting relationships, and positive word-of-mouth. A dissatisfied member or patient, on the other hand, generates potential new costs. Patients who are not happy with their plan or clinician may not follow clinical advice, can develop worse outcomes, and are likely to share their negative stories with friends and family members.
- ⚡ Third, existing patients and members are an invaluable source of information that can help health care organizations understand how to improve what they do and reduce waste by eliminating services that are unnecessary or not valued.



- ✍ Finally, poor customer service raises the risk of a negative “grapevine effect.” Over 50 percent of people who have a bad experience will not complain openly to the plan or the medical group. But research shows that nearly all (96 percent) are likely to tell at least 10 other people about their bad experiences (American Society for Quality 1999).

Health care organizations also need to pay attention to customer service because service quality and employee satisfaction go hand-in-hand. It is almost impossible to find high employee satisfaction in organizations that have low patient satisfaction. And organizations that place a premium on customer service tend to have high employee satisfaction as well.

Employees often are frustrated and angry about the same things that bother patients and members: chaotic work environments, poor systems, and ineffective training. No amount of money, signing bonuses, or other tools currently used to recruit hard-to-find staff will offset the negative impact of these problems on staff. The real cost of high turnover may not be the replacement costs of finding new staff but the expenses associated with lost organizational knowledge, lower productivity, and decreased customer satisfaction.

Why Word-of-Mouth Matters

Word-of-mouth reputation is important because studies continue to find that the most trusted sources of information for people choosing a health plan, medical group, doctor, or hospital are close family, friends, and work colleagues. When a recent survey asked people whom they would go to for this kind of information, over two-thirds of respondents said they would rely on the opinions of family members and friends (KFF/AHRQ 2000). In a study conducted by General Electric, “the impact of word-of-mouth on a customer’s purchase decision was twice as important as corporate advertising.” (Goodman et al. 1987)

Some Advice on Achieving Better Customer Service

The most successful service organizations pay attention to the factors that ensure their success: investing in people with an aptitude for service, technology that supports front-line staff, training practices that incorporate well-designed experiences for the patient or member, and compensation linked to performance. In particular, they recognize that their staff value being able to achieve good results, and they equip the staff to meet the needs of members and patients. For health plans, this could mean developing information systems that allow staff to answer members’ questions and settle claims quickly and easily; for provider organizations, it could mean providing the resources and materials that clinicians need to provide high-quality care in a compassionate, safe environment.

Experts on delivering superior customer service suggest that health care organizations adopt the following set of principles (Leebov, Scott et al. 1998):

1. Hire service-savvy people.
2. Establish high standards of customer service.
3. Help staff hear the voice of the customer.
4. Remove barriers so staff can serve customers.
5. Reduce anxiety to increase satisfaction.
6. Help staff cope better in a stressful atmosphere.
7. Maintain your focus on service.

Many customer-service programs have been developed for companies outside of health care. Although the strategies are similar, Leebov and Scott have adapted this work for health care settings in ways that increase its credibility and buy-in, especially from clinical staff. Their books and articles are packed with practical, step-by-step instructions about how to identify and solve customer service problems through the health care delivery system.

For More Details

Some of the strategies in Section 4 elaborate on the principles cited on the previous page. See:

/// *Idea D.1: Listening Posts*

/// *Idea D.5: Standards for Customer Service*

To learn more about all of these principles, please refer to the following books:

/// Leebov W, Afriat S, et al. *Service Savvy Healthcare: One Goal at a Time*. San Francisco, CA: Jossey-Bass / AHA Press, 1998.

/// Leebov W, Scott G, et al. *Achieving Impressive Customer Service: 7 Strategies for Healthcare Managers*. San Francisco, CA: Jossey-Bass, 1998.

/// Leebov W, Scott G, et al. *Service and Quality Improvement: The Customer Satisfaction Strategy for Health Care*. Chicago, IL: American Hospital Publishing, Inc., 1994.

Recognizing and Rewarding Success

The pursuit of better performance benefits greatly from positive incentives, whether at the organizational level or the individual level. Rewards can be financial or non-financial, but what matters is that they are directly linked to either the effort to improve or, ideally, the actual improvement.

External Rewards

The last several years have seen a growing interest in the idea of rewarding health care organizations that exhibit good quality or a commitment to improving their performance. Until recently, most of these rewards have come in the form of public recognition. For example:

/// The Pacific Business Group on Health, a large business coalition in California, awards a “Blue Ribbon” to the health plans that meet specified performance standards each year.

/// The National Business Coalition on Health, an organization of nearly 90 employer-led coalitions in the United States, recently initiated an annual “Innovation Awards” program in which health plans compete for recognition in several categories, such as consumer education and disease management. A panel of experts evaluate the entries that health plans submit; winners are recognized at the annual NBCH conference.

Superior performance also receives public recognition through the growing use of health plan and provider organization “report cards.” Many large employers, local buying coalitions, and government purchasers (such as Medicare and state Medicaid agencies) are producing printed and Web-based reports with comparative information on the quality of health care organizations (mostly plans and hospitals). Their goal is to provide employees and beneficiaries with better information for making health care decisions.

These public reports often highlight organizations that achieve better results than others on standardized measures such as CAHPS and HEDIS. While the impact of public reporting has not been extensively evaluated, there is some evidence that making performance information public stimulates quality improvement activities in areas where performance is reported to be low (Hibbard, Stockard et al. 2003).

More recently, purchasers and payers have explored ways of offering either increased market share or higher financial payments for good quality:

- ✦ Both General Motors (GM) and the Buyers Health Care Action Group (a purchaser coalition based in the Twin Cities) have programs to direct employees to higher quality plans and providers. GM sets lower employee contributions for plans with higher quality scores. The Twin Cities group similarly adjusts employee premiums according to cost tiers that enable consumers to identify quality differences among care systems.
- ✦ In California, a multi-stakeholder leadership group called the Integrated Healthcare Association (IHA) has initiated a statewide “pay for performance” program. In this program, six health plans will use common measures to evaluate the performance of their contracted physician groups serving commercial HMO enrollees, and develop individual bonus programs that will pay significant financial incentives based on that performance.
- ✦ The “Bridges to Excellence” program is a national group of employers, physicians, health plans and patients committed to realigning everyone’s incentives around higher quality. Bridges to Excellence will encourage increased accountability and quality improvements through the release of comparative provider performance data, as well as through higher payments to providers that meet specified quality goals.
- ✦ The Central Florida Health Care Coalition plans to set payments to individual physicians according to their performance on a combination of patient survey scores and clinical quality measures.

Internal Rewards

External reward systems motivate the leadership and the staff of an organization to focus on quality. Internal reward systems pay close attention to the front-line staff and middle managers who do what is necessary to achieve the external rewards. Reward and recognition programs usually include formal programs, day-to-day feedback, and informal recognition programs.

Formal Programs

Examples of formal programs include:

- ✦ Staff Recognition awards that focus on different behaviors, i.e., service excellence, clinical competence, teaching, and mentoring
- ✦ Years of service awards: 5, 10, and 25 years

Day-to-Day Feedback

Managers provide consistent and timely feedback to employees about their performance. Experts confirm that providing praise in a timely manner does have a positive effect on employee motivation and sense of belonging. Some organizations develop formal coaching programs to assist managers in coaching and providing feedback to their employees and peers.

“Creating loyalty means giving employees more for their labor than just a paycheck. Both research and personal experience tell us that people work for a sense of accomplishment and the recognition of others”.

(Gelinas and Bohlen 2002)

Informal Recognition Programs (e.g., R.E.W.A.R.D.)

Many employees go above and beyond their assigned duties to assist patients, other staff, clinicians, and the community. It is important to encourage the recognition of these individuals for their customer service, teamwork, integrity, or overall positive attitude. Research indicates that informal recognition by managers is a key motivating factor for effective job performance (McElroy 2001).

One example of an informal program is called R.E.W.A.R.D., which stands for Recognition of Employees When Achievement & Responsibility is Displayed:

How to Recognize

Some organizations create a J.A.C.K. In-The-Box, where J.A.C.K. stands for Job Acknowledgement Care Kit. The JACK In-The-Box provides a number of rewards that can be used for instant recognition when situations “pop” up. These can include gift certificates, time off, extra vacation days, or other small tokens of appreciation scaled to fit the accomplishment.

Draw on your understanding of the person you want to recognize when selecting the recognition item. Some people like public recognition of their efforts; if you are not sure, ask the person what he or she would be comfortable with.

When to Recognize

There are no rules about how often recognition should take place. Ideally, recognition should take place as soon as possible, whenever you want to say “Thanks” or “Congratulations”

What to Recognize

People can be recognized for many things. Here are just a few:

- ✦ Exceptional job performance
- ✦ Excellent team work
- ✦ Outstanding customer service
- ✦ Extraordinary performance of regular duties in a particularly difficult circumstance
- ✦ Extremely good performance of regular duties over a long period of time

Rewards That Go Beyond the Individual

Rewards can also be actions and changes that support the entire organization and help transform the culture. Examples include the following:

- ✦ Improve your systems to “make it easy to do the right thing” and improve quality of life for front-line staff.
- ✦ Make sure people have the aptitude, training, and the resources they need to do a job well done.
- ✦ Give star performers the opportunity to attend conferences of their choice and/or receive tuition reimbursement for courses that advance their expertise.
- ✦ Tell stories, create legends and celebrate “heroes.”
- ✦ Help people get recognition internally and externally through presentations at meetings and conferences, newsletters, and local media.
- ✦ Recognize people personally for behavior consistent with the organization’s stated philosophy and rules.
- ✦ Use thank you notes, voice mailboxes that allow patients to compliment staff, and public postings of thank-you letters from grateful patients and families.
- ✦ Be aggressive about the management of poor performers (i.e., staff who do not uphold the values and culture of excellence).
- ✦ Show respect for people. Start everything on time.
- ✦ Invite front-line staff to meet with senior management and the board routinely to improve communication and trust in management.

- /// A “Good Catch” (i.e., the person took the initiative to nip a problem in the bud or avoid a disaster)
- /// Active participation in projects
- /// Applying new skills and knowledge
- /// Meeting goals and targets
- /// Displaying commitment and loyalty to the organization
- /// Demonstrating innovation through new ideas and initiatives

Orientation

Orientation of new employees is the best place to begin the education about the culture of your organization. It is also an excellent way to highlight how the internal reward and recognition system is linked to the philosophy of care and organizational standards.

The objective of orientation should be to do the following:

- /// Instill a feeling of self-worth
- /// Create a sense of belonging
- /// Develop an attitude of pride and confidence in oneself and the organization
- /// Spark a desire to succeed
- /// Enhance the relationship between the employee and the organization

Compensation and Benefits

Compensation and benefits can be designed to reinforce the desired behaviors and performance standards of the organization. Compensation levels can be linked to meeting service-oriented performance standards, coaching and mentoring goals for managers, and other indirect reward activities such as completing performance reviews on time.

Cafeteria-style benefit packages help meet the needs of a diverse work force without creating a sense of inequity in your workforce. Some organizations offer unusual benefits such as pet insurance, health club memberships, flexible spending accounts for medical and childcare expenses and even home financing assistance and education.

In summary, there are many effective ways to reward and recognize employees. The most important consideration in the design of your program is to make sure your program supports your organization’s culture and philosophy of care.

“Most people can’t sleep the night before their first day of a new job. They probably decided two weeks in advance what they’d wear. They can’t wait to get started, meet new people, see everything, do great things. After all of the anticipation, their first day is usually a big yawn. They find themselves hidden away in a room somewhere filling out forms. What a mistake! First impressions are lasting.”

—Hal Rosenbluth, *The Customer Comes Second*. New York, NY: Harper Business, 2002.

For More Information

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- Tucker F, Gaither S, Zivan M, Camp RC. How to Measure Yourself Against the Best. *Harvard Business Review*, January/February, 1987: 8-10.

Section 2: Using CAHPS to Identify Opportunities for Improvement

CAHPS data can help you pinpoint opportunities for improvement at both the health plan level and the medical group level. However, it is not sufficient to simply look for the composites with low scores. You need to know how your scores compare to those of other organizations and which issues are most relevant to consumers.

This section explains how to interpret what CAHPS data tell you about your organization's strengths and weaknesses. It also suggests ways to consult other sources of performance data in your organization and conduct further analyses that can confirm or more precisely define the problem(s) you wish to focus on. Specifically, this section presents five ways in which you can analyze your performance:

- /// Analyze performance compared to benchmarks
- /// Identify key drivers of poor performance
- /// Analyze performance at a more detailed level
- /// Identify changes, or trends, in performance
- /// Consider other indicators of performance

In some cases, you may be able to obtain sufficient information from using just a few of these methods. However, each one should offer progressively greater insight into the data. Where possible, the discussion includes examples of how actual health plans and provider organizations have analyzed their CAHPS survey data.

Analyze Performance Compared to Benchmarks

A review of your CAHPS survey results will yield little useful information about opportunities for improvement unless you are able to answer the question, “compared to what?” Thus, before you can identify specific problem areas, formulate an improvement plan, and select appropriate strategies, you have to look at your results in the context of appropriate and relevant benchmarks.

In addition to examining the comparison norms that your survey vendor may have provided, you can use any of three major sources of national CAHPS benchmarks to assess your survey results:

- /// National CAHPS Benchmarking Database
- /// National Committee for Quality Assurance's (NCQA) Quality Compass
- /// CMS's CAHPS Survey Results for Medicare Managed Care Plans and the Traditional Medicare Program

National CAHPS Benchmarking Database

Funded by the Agency for Healthcare Research and Quality (AHRQ), the National CAHPS Benchmarking Database (NCBD) is the national repository of CAHPS survey data. All sponsors of CAHPS surveys that are administered independently according to CAHPS survey specifications are invited to participate in the NCBD. Participating sponsors include state

Medicaid agencies, State Children's Health Insurance Programs (SCHIP), public and private employers, individual health plans, Medicare, and the Department of Defense.

Commercial, Medicaid, and SCHIP sponsors submitting data to NCBD receive a free, customized report that compares their own results to the following:

- /// National results for adults
- /// Results for the plan model type
- /// Results for the local sponsor's market

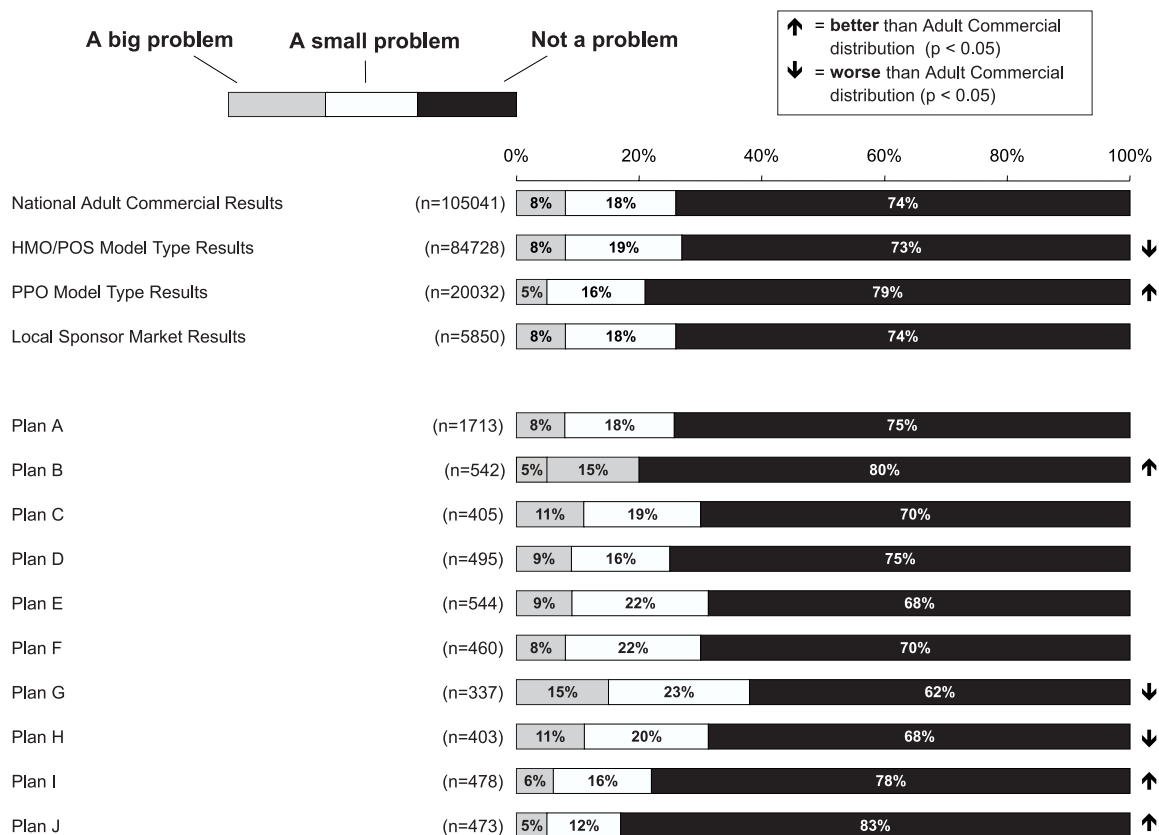
All results are case mix-adjusted to account for differences in respondent age, education, and self-reported health status. Detailed bar charts display results for each of the CAHPS composites, individual items, and ratings. The intent of these comparisons is to help plans identify potential strengths and weaknesses in their performance and to target areas for quality improvement. A sample bar chart from an NCBD report is shown in Figure 1.

Further information on the NCBD is available on the NCBD Web site (<http://ncbd.cahps.org>).

Figure 1. Sample Comparative Bar Chart from an NCBD Report

Getting Needed Care

This chart displays the data for "Getting Needed Care", an aggregate of survey questions 7, 9, 24, and 26. Results for the individual questions are displayed on each of the following pages.



NCQA Quality Compass

The National Committee for Quality Assurance (NCQA) maintains a database of CAHPS survey data obtained from health plans that have submitted their results for accreditation or as part of their annual reporting of HEDIS measures. The NCQA Quality Compass database includes both summary level and respondent level data. Several combinations of data files are available for purchase. You can use these data files to create reports that address your specific needs.

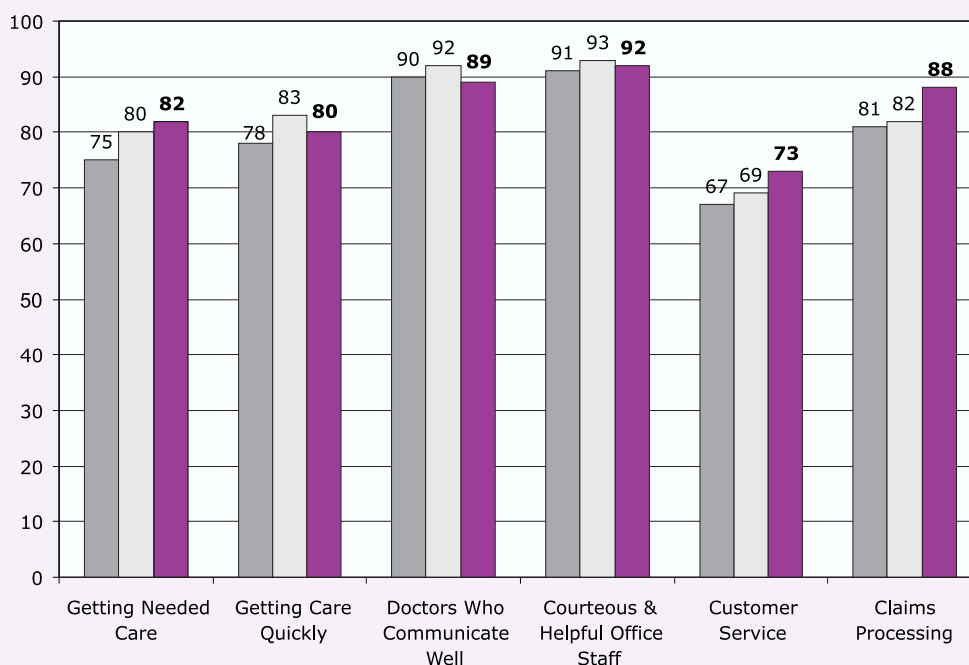
In addition to the Quality Compass database, NCQA also publishes an annual *State of Health Care Quality* report that provides regional CAHPS benchmarks, but only for rating items and report composites (not individual items). This annual report also provides trend data for these measures, but only at the national level.

Case Example: Comparing Harvard Pilgrim's CAHPS Results to National and Regional Benchmarks

Harvard Pilgrim Health Care is a large managed care organization based in Boston, Massachusetts. The plan has implemented and used CAHPS for several years, both to comply with NCQA accreditation requirements as well as to monitor and improve performance on key aspects of the enrollee experience.

In analyzing its 2001 CAHPS results, Harvard Pilgrim found that some of its CAHPS scores lagged behind either or both national and regional averages. The chart below shows the plan's composite scores compared to benchmarks obtained from the NCQA's Quality Compass 2001. The comparison indicates lower than regional performance for the "Getting Care Quickly" and "How Well Doctors Communicate" composites.

Figure 2: HPHC Performance on CAHPS Composites Compared with National and Regional Averages (NCQA Quality Compass 2001)



Source: Harvard Pilgrim Health Care, 2002

■ National Average ■ NE Regional Average ■ HPHC, Inc.

CMS's CAHPS Survey Results for Medicare Managed Care Plans and the Traditional Medicare Program

Since 1998, CMS has been collecting CAHPS survey data each year for all managed care plans serving Medicare beneficiaries. More recently, CMS began collecting data for its traditional Medicare program as well. Selected results of these surveys are available to plans, providers, and the public through the Medicare Compare Web site (www.medicare.gov).

The Agency also provides its managed care plans with a detailed print report and a CD-ROM containing their Medicare Managed Care CAHPS (MMC-CAHPS) results at the contract level. Starting in 2003, CMS will provide an on-line interactive system for viewing CAHPS results (see more details in the box on page 30).

Like the previous reports, the MMC-CAHPS reports show how the results for each of the Medicare managed care plans within a state compare to state, regional, and national averages. They also provide national benchmarks based on the performance of plans in the 90th percentile. The report includes detailed bar charts as well as an executive summary with highlights of the health plan's "strengths" and "opportunities for improvement," defined as CAHPS scores that are statistically higher or lower, respectively, than the state average.

Identify Key Drivers of Poor Performance

Once you have completed the basic analysis to identify areas of relative weakness, the next stage is to figure out what specific problems are behind the poor performance.

What Influences Overall Ratings?

There are many ways to identify areas for which you want to develop improvement activities. These include how common the problem is, how different your plan or medical group score is from others, existing opportunities for improvement activities, and how important the issue is. One way to assess the "importance" of an issue is to assess how strongly a particular rating is associated with a patient's overall rating of their care or health plan. This is an indirect way of assessing how important different issues are to your enrollees.

A statistic commonly used to assess such associations is called a correlation coefficient. A correlation can range from -1.0 to +1.0. If the correlation is between zero and 1, then the overall rating (e.g., how would you rate your care?) is positively influenced by the responses to the problem question (e.g., did you have a problem getting care you needed?). A correlation coefficient of 1.0 means the overall rating is perfectly correlated with the problem question. If the correlation is zero, the two are independent, i.e., not related.

Using correlations to determine what specific issues are related to overall ratings is sometimes referred to as "key driver" analysis. This type of analysis can be conducted on large or small samples of data. It is important to analyze your own data for such correlations, because they can be different for each sample.

As an example, Table 4 below presents correlations between the CAHPS composites and the overall ratings of doctor, care, and plan for the 1999 Medicare managed care survey data. (Appendix B shows the correlations between responses to specific CAHPS items and the overall ratings using the same data.) The white boxes indicate composites that appear to be important predictors of ratings because the correlation coefficients are greater than 0.45. Determining what is a high or low correlation is often a matter of judgment, and should be informed by looking at analyses of several different samples to see how they compare.

Table 4. What Drives Ratings? An Example from Medicare
Correlations between CAHPS Composite Scores and Overall Ratings
for Medicare Managed Care Respondents*

Composite	Doctor Rating	Care Rating	Plan Rating
Getting Needed Care	0.31	0.45	0.38
Getting Care Quickly	0.31	0.43	0.30
Getting Care	0.15	0.24	0.30
Health Plan Information and Customer Service	0.15	0.27	0.51
Customer Service Helpful	0.19	0.32	0.59
Courtesy and Respect of Doctor's Office Staff	0.35	0.49	0.32
Communication with Providers	0.51	0.67	0.40
Getting Special Services through the Health Plan	0.21	0.33	0.41

* The plan-level composites listed in Table 4 and Appendix B are different than the reporting composites for the CAHPS Health Plan Survey because the analyses are based on associations between plan scores, in contrast to analyses that examine relationships among responses by the same individual.

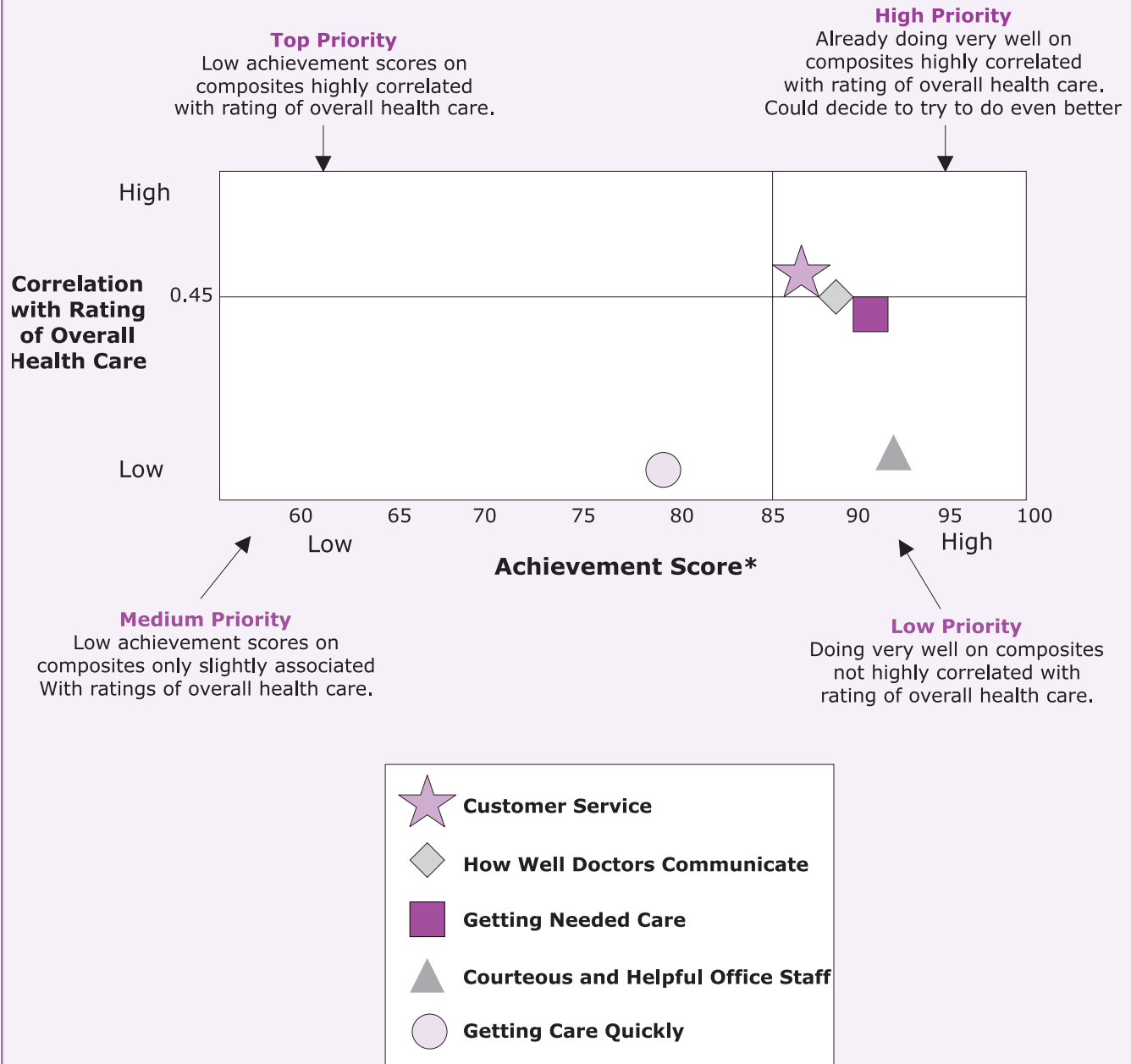
Source: 1999 Medicare Managed Care CAHPS Survey

A Graphic View of Improvement Opportunities

Although you can use correlation scores to help identify specific composites or questions for focusing improvement efforts, a graphic that displays both the level of a problem and the correlation can make it easier to set priorities. For example, Figure 3 on the next page plots the value of each composite score (transformed to a 0 to 100 scale) and its correlation coefficient for the Rating of Overall Health Care. By looking at this picture, one can quickly judge that “customer service” would be an important area to focus on.

These kinds of analyses and graphical representations of relationships are not difficult to do, but they do require time and access to statistical support. Many survey vendors are capable of providing these services as part of the CAHPS data collection and reporting process.

Figure 3: Priority Matrix of CAHPS Composites Based on Correlation of Composites to Rating of Overall Health Care



* An achievement score is ranked "high" when score is 85 or higher.

** An association with Overall Health Care is ranked "high" when correlation is .45 or higher.

Analyze Performance at a More Detailed Level

When diagnosing or targeting problems, it is often helpful to take a closer look at the details underlying your CAHPS results. This section discusses how you can conduct more detailed analyses of performance at the level of population sub-groups and at the level of provider sub-groups.

Analyses with Population Sub-Groups

You can use simple cross-tabulations and statistical tests for differences in proportions to identify important differences in care experiences across different population sub-groups. For example, analyzing your CAHPS results by the age, gender, race, or health status of survey respondents can reveal groups of consumers or patients with particular problems that are not obvious when looking only at the overall results at the level of the plan or provider group. Additionally, many of the items used as “screener” questions in CAHPS (e.g., “In the last 12 months, did you see a specialist?”) can be useful for defining population sub-groups for broader analysis, i.e., not just to analyze the items to which the particular screener was attached. This type of detailed analysis can also point you towards potential paths for designing improvement strategies and targeting intervention efforts, so that you can focus resources in a way that achieves maximum benefit.

Examples of key population sub-groups that can be defined using standard CAHPS items include:

Population Sub-Group	Examples/Options
Male/Female	
Age group	Young adults, adults, older adults, elderly, etc.
Educational level	
Race/Ethnicity	
English/Non-English, if known	Options include tracking the survey version used, if translations are available, or response of “translated the questions into my language” in the item on how someone helped you complete the survey
Tenure with health plan	Question 4 on CAHPS 3.0H (HEDIS version of CAHPS)
Tenure with provider, if available	Options include an additional item added to sampling frame file that vendor can later append to results file or adding a supplemental survey item
Health care utilization	Saw a specialist, sought phone advice, made a routine appt, had an illness or injury that needed care right away, used emergency room (0, 1, >1), number of visits to doctor’s office
Plans services utilization	Sent claims, sought information, called customer service, complained, experienced paperwork
Rating of health	

CMS Offers Interactive Tool to Analyze Results by Characteristics

CMS's Health Plan Management System (HPMS), which is available to Medicare managed care plans, includes an on-line interactive module for viewing results from the Medicare Managed Care CAHPS (MMC-CAHPS) surveys. (See <http://www.cms.gov/healthplans/hpms/>). This new tool will allow health plans, CMS staff, and researchers to either explore MMC-CAHPS information from a prior year (data is available from 1998 on) or explore current data in new ways.

The CAHPS Module of the HPMS includes the following features:

- /// **Summary:** Provides an overview of plan-level and state-level information regarding composite ratings, overall ratings, preventative care rates and response rates.
- /// **Survey Results:** Allows users to view detailed results and frequency tables and download complete health plan reports as PDF files.
- /// **Special Analyses:** Allows users to view:
 - survey results by beneficiary characteristics such as age, gender, race, and health status;
 - comparisons of managed care to fee-for-service results at the national and state level;
 - a report describing response patterns to the MMC-CAHPS survey of current members; and
 - reports of selected analyses by the MMC-CAHPS team (covering topics such as the reports and ratings of vulnerable sub-populations and the stability of the CAHPS rating over time).

More sophisticated analysts may want to consider using multiple regression techniques to identify population differences in care experiences and/or ratings. In a series of regression equations, the dependent variable would be the individual rating item responses or dichotomized report item responses (e.g., Problem vs. No Problem, Always or Usually vs. Sometimes or Never), while the independent variable would be dummy variables for the population sub-groups (as listed above). This approach also permits the use of interaction terms (e.g., age/sex, health care utilization, and health rating).

Analyses of Provider Sub-Groups

Another approach involves analyzing your CAHPS data at the medical group or practice site level. This type of "sub-plan" analysis usually requires additional sampling of enrollees or patients in order to have enough survey responses to be able to meaningfully compare CAHPS scores across specific groups or practice sites. This is especially true if medical groups or practice sites differ either in the population sub-groups they serve or in how they serve various population sub-groups. (Keep in mind that some sub-groups may not be large enough to allow for analyses of performance at the level of the delivery system or medical group.) Although additional data collection is required, the extra cost and effort could be worth it, as illustrated by the example of Harvard Pilgrim Health Care in the box at right.

Table 5. Analyzing Medical Group Performance at Harvard Pilgrim

As noted earlier, Harvard Pilgrim found that some of its CAHPS scores lagged considerably behind both national and regional averages as well as some of its key competitors in the Massachusetts market. By analyzing the data more finely at the medical group level, Harvard Pilgrim discovered that one particular medical group's CAHPS scores were lower than those of the rest of the plan's provider network.

As shown in the table below, this particular medical group's scores for 2001 had declined significantly from 2000 levels in several areas. Based on these findings, Harvard Pilgrim decided to target its initial intervention activities with this medical group rather than throughout the entire provider network. See the case example on page 44 to learn more about this intervention and its results.

CAHPS Composites/Items	Harvard Pilgrim	Difference (Group- Plan)	Medical Group		
	2001	(+/-)	2001	Difference: 2000-2001 (+/-)	2000
Getting Care Quickly (% Always/Usually)					
Get help when called during regular office hours	85.5	-2.0	83.5	-8.3	91.8
Get appointment for regular/routine care	76.8	-7.3	69.5	-13.8	83.3
Get appointments for illness/injury	87.5	-8.3	79.2	-9.5	88.7
Wait at doctor's office or clinic more than 15 minutes (% Never/Sometimes)	69.7	10.7	80.4	4.0	76.4
How Well Doctors Communicate (% Always/Usually)					
Doctors/health providers listen carefully	89.2	-2.2	87.0	-6.4	93.4
Doctors/health providers explain things understandably	92.4	-2.0	90.4	-6.8	97.2
Doctors/health providers show respect	90.8	-0.4	90.4	-5.8	96.2
Doctors/health providers spend enough time	84.6	-1.5	83.1	-3.1	86.2
Courteous and Helpful Office Staff (% Always/Usually)					
Office staff treated with respect	95.0	0.9	95.9	0.7	95.2
Office staff helpful	89.8	0.7	90.5	-2.0	92.5

Source: Harvard Pilgrim Health Care, 2002.

Identify Changes in Performance Over Time

Whether you are comparing your CAHPS scores to data from external sources or investigating performance at the sub-population or sub-plan level, it can be useful to track whether and how performance has changed over time. Monitoring progress from year to year can help substantiate whether a perceived problem area is real or just a one-time dip, and can also reveal whether or not actions taken to address problems are having the desired effect. For the purposes of quality improvement, the collection of data should be both frequent and targeted so that you can assess the impact of interventions over time.

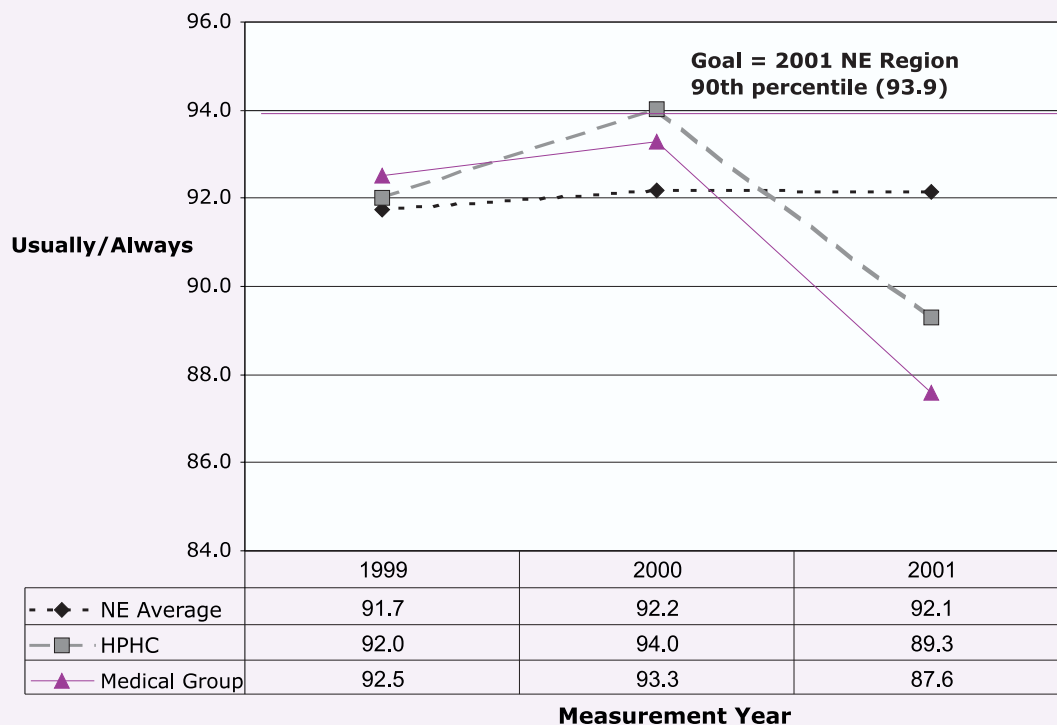
Of course, the ability to track performance over time requires the use of periodic and consistent surveys. When measures change, it may be difficult to identify trends. Because of changes in three of the four items in the “Getting Care Quickly” composite, for example, Harvard Pilgrim was unable to follow through on a planned intervention to reward a medical group’s performance based on trend analyses for this measure.

Table 6. CAHPS Performance Trends at HPHC

At Harvard Pilgrim, analyses indicated that some of the plan’s CAHPS scores were trending down while national scores, on which the NCQA accreditation benchmarks are based, were trending up. For example, for both the plan and the medical group referred to in Table 5, the composite score for “How Well Doctors Communicate” declined significantly from 2000 to 2001, after having risen between 1999 and 2000. This change signaled a need to further explore this aspect of the group’s performance. A discussion with the medical group about the reasons for their dramatic decline reinforced the plan’s decision to focus an intervention on this area of the group’s performance. See the case example on page 44 to learn more about this intervention and its results.

Doctor Communication Composite Top Box Scores Over Time

Medical Group versus Benchmarks: 1999-2001



Source: Harvard Pilgrim Health Care, 2003

Consider Other Indicators of Performance

As a supplement to the CAHPS survey results, you may want to consult other data sources related to service quality to gain a more complete picture of performance or to verify suspected problem areas. Examples of these other data sources include enrollee complaint and grievance data, topic-specific survey data, and feedback from your staff about recurring problem areas.

One benefit of performance indicators from data sources such as complaints and grievances is that you can typically see the impact of changes in process more quickly than you can with CAHPS survey data obtained once a year. This is due to the lag time associated with the CAHPS survey administration process, as well as the 12-month reference period for survey respondents. The ability to use multiple data sources to corroborate changes in performance, in the form of improvements or declines, will greatly enhance the accuracy of performance monitoring and the effectiveness of interventions over time.

Getting Behind the Numbers: Focus Groups and Interviews

In the face of uncertain or ambiguous survey results, a common tendency for many quality improvement managers is to decide to do yet another survey. But sometimes you have to get the story “behind the numbers” and learn more about the problem through focus groups or key informant interviews. These qualitative techniques, applied in groups or individually with staff, members, and patients, can provide insights that cannot be achieved through data analysis alone.

For example, if a medical practice received poor scores on the question,

“In the last...months, when you called during regular office hours, how often did you get the help or advice you needed (for your child)?”

the QI team might assume that the problems is related to waiting on hold for too long. Through staff interviews, patient interviews, and perhaps a “walkthrough” of the phone system, you may identify other problems. Perhaps the voice message has a lengthy set of choices that have nothing to do with patient needs, or the practice does not have enough phone lines so patients

Using Multiple Performance Indicators at HealthPlus of Michigan

HealthPlus of Michigan is a large HMO serving commercial, Medicaid, and Medicare enrollees in eastern mid-Michigan. An analysis of its 1999 and 2000 CAHPS data compared to national and state benchmarks showed lower than average performance in “Getting a Referral to a Specialist”. These lower CAHPS scores were corroborated by a high rate of complaints for referral timeliness and low ratings on a separate survey of members that had received referrals for specialty care.

In addition to the supplemental survey and complaint data, the plan obtained information about the timeliness of the referral process from internal administrative data sources. This was assessed at monthly intervals in relation to targeted goals. The plan then identified the key steps that support the timeliness of the referral process, and put in place processes and monitoring features to more effectively support meeting the goals. For example, the plan discovered that printing of referrals was at times delayed because of other priorities, so the process was changed to print the referrals daily. Since the intervention, member responses on the CAHPS survey questions related to the referral process have significantly improved and been retained.

get a busy signal. The problem may also stem from inefficient phone triage or poor communication between the people taking the messages from patients and the clinical staff. The appropriate intervention would depend on the precise nature of the problem.

Similarly, if a health plan scored low on the question,

“With the choices your (child’s) health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?”

the team might discover through interviews or focus groups with members and staff that the problem is related to the size or composition of the provider network. Or you may find that the score is driven by dissatisfaction with the provider directory. For example, a printed directory may be outdated by the time it goes to press. Or it may not include sufficient information to help people make informed choices, such as hours of operation, location of practices on public transportation lines, or languages spoken by the professional staff. The intervention to fix a wrong-sized provider network is totally different than the one required to provide a more member-centered provider directory.

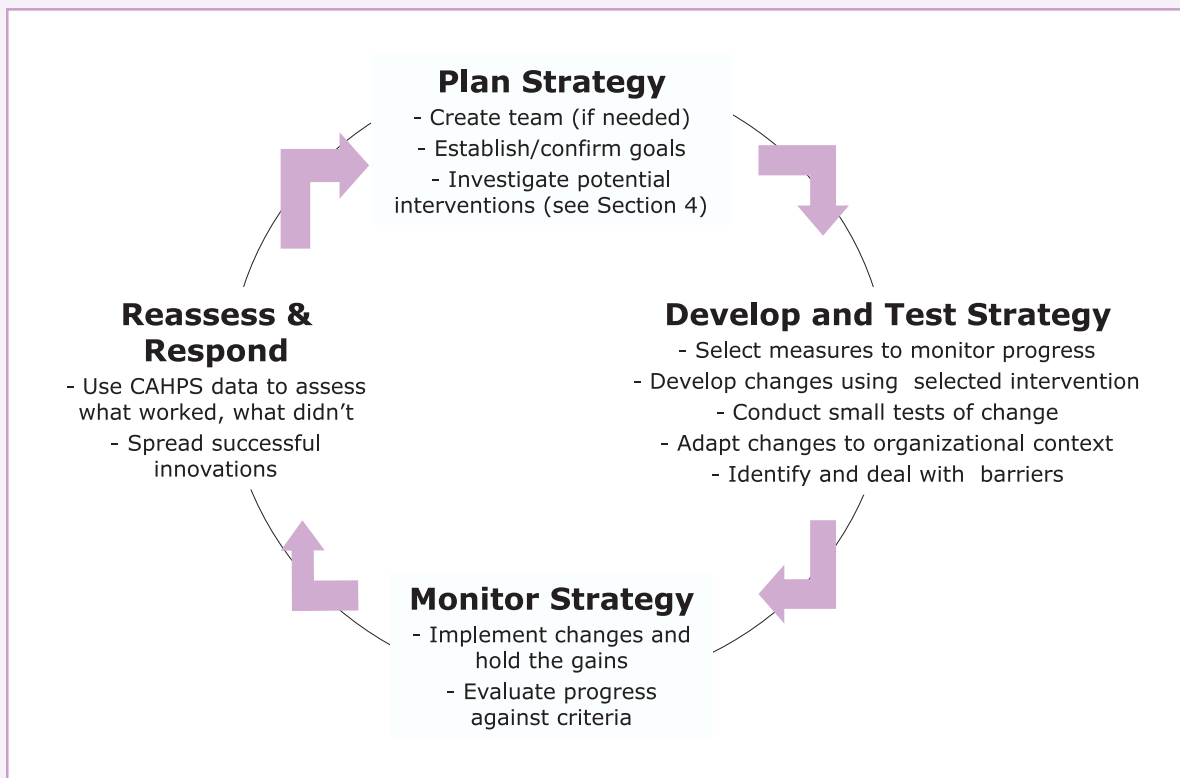
For more information on the use of focus groups and interviews, as well as a list of pertinent resources, see *Idea D.1: Listening Posts* in Section 4 of this Guidebook.

Section 3: Implementing the CAHPS Improvement Cycle

The analyses suggested in Section 2 can help you better understand the nature of any CAHPS-related performance problems and identify specific opportunities to improve services and care. Once you have completed these analyses, the next step is to identify and implement one or more appropriate strategies for addressing these problems.

It is important to remember that the effort to improve performance is not a linear process with a beginning and end, but a cyclical process that leaves room for testing, tweaking, and expanding interventions along the way. The following graphic lays out the basic elements of this cycle.

Figure 4: The Quality Improvement Cycle



This section offers a brief overview of the four steps laid out in this cycle. For detailed examples of how organizations are implementing this cycle, see the Institute for Healthcare Improvement's public Web site (www.QualityHealthCare.org). Under Topics, click on Office Practices: Access: Improvement Stories.

Plan Strategy

The first stage in the cycle is to prepare for change by bringing together the people who need to be involved, setting goals (or, if interventions have already been put in place, confirming that the goals have not changed), and investigating your options. As you complete each round of the improvement cycle, this stage becomes the point at which you adjust your plans and refine or add interventions.

Create a Team

The “right” team can play a major role in determining the success of a quality improvement initiative. The key is to carefully select people with the right skill set and mindset for quality improvement – people who are opinion leaders, are respected by their peers, and have appropriate expertise for the purposes of the intervention.

That said, it is better to choose people who are enthusiastic about the chance to improve care, even if they lack some of the formal skills or responsibilities. Sometimes staff are selected for a team because of their titles or their clinical or administrative expertise, even though they are clearly not convinced that quality improvement is effective or that patient opinions matter. These teams are rarely successful because they spend most of their time debating about whether they should even be involved or they simply do not show up or do the work.

Also, it is important to recognize that a team may consist of only one or two people, especially in a smaller medical practice where each staff person may have multiple responsibilities. This approach is fine, as long as it is a conscious decision rather than an oversight.

In larger organizations, effective performance improvement teams typically include:

- /// A senior leader responsible for providing resources, removing barriers, and publicizing the work of the team through the organization;
- /// A physician or nurse leader if the intervention involves any aspect of clinical care;
- /// A team leader who is usually someone with administrative or clinical responsibility at the microsystem level. This person could be a nurse, a practice manager, a pharmacist, or the supervisor of a call center, depending on the focus of the team;
- /// A data analyst to track the performance measures and share them with the team and senior leader; and
- /// Other team members who represent the different disciplines or types of staff who own a “piece of the problem”.

Once the team has been established, its job is to initiate the process of improving performance by developing answers to the following questions (Langley, Nolan et al. 1996):

- /// What are we trying to accomplish?
- /// How will we know that a change is an improvement?
- /// What changes can we make that will result in improvement?
- /// How can we test and refine interventions over time?

Resources on Teamwork

Katzenbach J, Smith D. *The Wisdom of Teams: Creating the High Performance Organization*. Boston, Massachusetts: Harvard Business School Press, 1993.

Lawrence D. *From Chaos to Care: The Promise of Team-Based Medicine*, Cambridge, Massachusetts: Perseus Publishing, 2002.

Scholtes P. *The Team Handbook: How to Use Teams to Improve Quality*. Madison, WI: Oriel, Inc., 1996.

Establish/Confirm Goals

The team's first task is to establish an aim or goal for the improvement work. By setting this goal, you will be better able to clearly communicate your objectives to all of the sectors in your organization that will be needed to support or help implement the intervention.

The goal should reflect the specific aspects of CAHPS-related performance that the team is targeting. It should also be measurable and feasible. One of the limitations of an *annual* CAHPS survey as a measurement tool is the lag time between the implementation of changes, the impact on people's experiences, and the assessment of that impact. For that reason, the team needs to define both ultimate goals as well as incremental objectives that can be used to gauge short-term progress.

For example, a team concerned about improving performance on the "getting care quickly" composite may set a one-year goal of a 10 percent increase in its composite score. At the same time, it could specify goals for the number of days it takes to get an appointment for a non-urgent visit, or the length of time that patients wait to see a clinician. Similarly, a team focusing on overall ratings may set goals for complaint rates for the plan as a whole or for individual medical groups, which can be tallied and reviewed on a monthly basis.

Examples of Aims for Improving Access to Clinics

Collaborative teams working on improving access to care established the following aims for their project:

- /// 50% reduction in current waiting time (in days) to see a urologist
- /// Same-day access to primary care physicians
- /// Decrease the office visit cycle time to 30 minutes or 1.5 times the actual time spent with the clinician

Investigate Potential Interventions

With objectives in place, the next task of the team is to identify possible interventions and select one that seems promising.

How to Find Possible Solutions

Section 4 of this Guidebook reviews a number of different strategies that health care organizations can use to improve different aspects of their CAHPS performance. This digest of QI ideas offers an excellent starting point, but it is by no means comprehensive. There are many sources for new ideas or different ways of doing things both within and outside of health care. Consequently, QI teams should make an effort to develop and cultivate systematic ways of identifying effective solutions.

All improvement requires making a change but not all changes lead to improvement.

Innovation: It's Only New to You

In health care, innovation does not necessarily refer to the creation of *new* ideas but to the introduction of previously unknown ways of providing care or services. A new idea might result in a new treatment for a disease or new form of technology such as the MRI. But innovation in health care can also happen when an idea from another industry is applied in a completely different way in a health care organization.

"Innovation is the conception, early adoption and implementation of significant new services, ideas, or ways of doing things in order to improve or reform services or ideas and ways of doing things." — Everett Rogers, Diffusion of Innovation

New ideas and innovative solutions can be found at conferences or workshops; in the academic literature, the media, and/or the popular press; and through the identification of benchmark practices in health care as well as from other industries, i.e., non-competitive benchmarks. Another important source of ideas and strategies is patients and their families – whether through direct interviews, focus groups, or Patient and Family Advisory Councils.

Another useful way to develop and learn innovative approaches is by participating in a learning collaborative or an action group. Sometimes organizations send a well-chosen team to participate in learning collaboratives and then have the team set up a “shadow collaborative” at home to help foster the spread of innovation.

Another effective tactic is to travel to other places. Resistant or hesitant staff members are often “unfrozen” by visiting another highly respected site that has successfully implemented a similar project or by visiting an industry or company outside of health care to get new ideas. Some health plans, for example, have learned how to improve their call center operations by sending staff to visit mail-order catalog houses or brokerage firms.

How to Choose an Intervention

In order to decide which new ideas or benchmark practices to implement, the QI team needs to consider several factors:

- /// **Compatibility with the organization and local culture:** Serving Cuban coffee in the waiting room of the clinics of a Miami health plan may be very member-friendly, for example, but it is not likely to be viewed with the same enthusiasm by plan members in Arizona or Massachusetts.
- /// **Technical merit:** The ideas that are most likely to be adopted are those that provide significant advantages over existing practices for both patients and providers – whether in the form of increased efficiency, higher patient and employee satisfaction, or improved outcomes. All QI efforts ultimately have to answer the question: “What’s in it for me?” Most of the ideas presented in Section 4 of this Guidebook meet these criteria, in that they make life better for all involved.

“Ideas for change can come from a variety of sources: critical thinking about the current system, creative thinking, observing the process, a hunch, an idea from the scientific literature, or an insight gained from a completely different situation. A change concept is a general idea with proven merit and sound scientific or logical foundation, that can stimulate specific ideas for changes that lead to improvement.”

(Plsek 1999)

What Is a Learning Collaborative?

A collaborative is a learning model that combines expert faculty working over time with teams from multiple organizations or multiple teams from within one organization to improve a specific problem (e.g., poor patient satisfaction), a process (e.g., improving flow or decreasing waits), a site of care like the emergency department or the intensive care unit, or care for a clinical condition (such as asthma or diabetes). Collaboratives require that the teams share information on their variations in practices and their successes.

- ✍ **Fit with the problem:** The best intervention will be one that suits the specific problem you need to address (or can be tailored as needed). To ensure a good fit, the QI team should seek input from both affected staff as well as patients or members. If you ignore either source of information in your planning, you may choose an intervention that will not fix the real problem.

Develop and Test Strategy

Once you have selected an intervention, the next stage of the cycle is to develop and test specific changes. It helps to think of this stage as a number of “mini-cycles” within the larger improvement cycle, in the sense that the team is likely to go through multiple iterations of testing and refining before the specific changes add up to a real intervention. These mini-cycles are often referred to as PDSA, which stands for Plan, Do, Study, and Act. To learn more about this approach, see the Institute for Healthcare Improvement’s public Web site at www.QualityHealthCare.org.

Some of the tasks involved in this process include:

- ✍ Selecting measures to monitor progress
- ✍ Developing changes using selected intervention
- ✍ Conducting small tests of change
- ✍ Adapting changes to organizational context
- ✍ Identifying and dealing with barriers

Select Measures to Monitor Progress

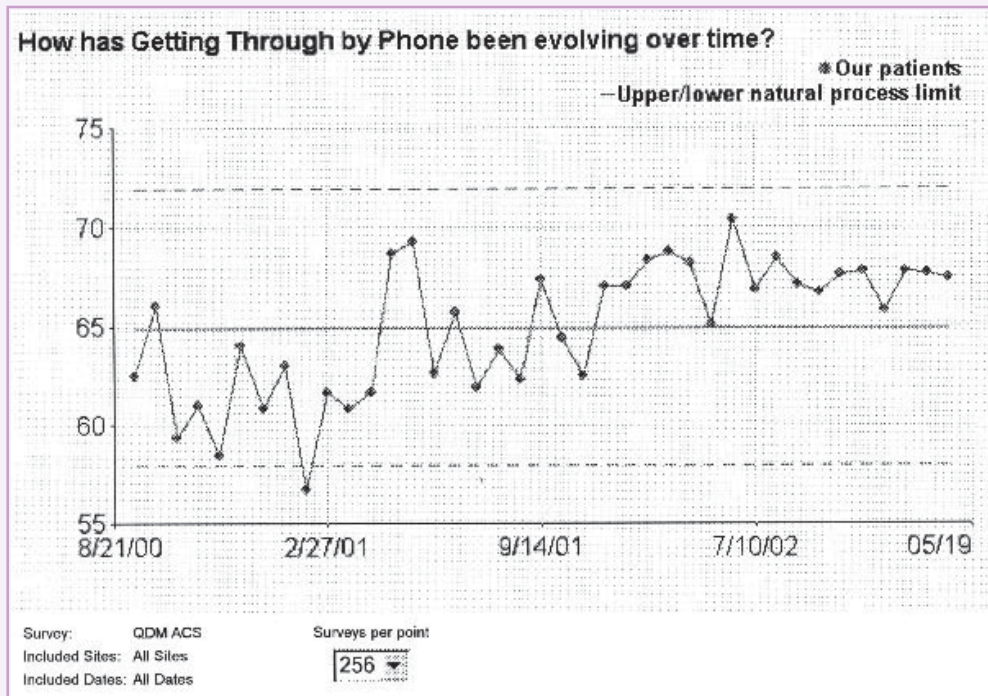
When a team establishes its goal, it typically specifies one or more performance metrics that will allow it to assess whether a change actually leads to improvement. These measures should be clearly linked both to the larger goal and to the intervention itself. For example, if the goal is to speed specialist referrals, you could measure the time it takes to get a response from the specialist’s office or an approval from the health plan. See Table 7 on the next page for a detailed example of measures and goals for an intervention to improve asthma care.

Once you have established practical measures, you will be able to produce visual displays of your performance over time by tracking the metric on control or run charts. Control and run charts are helpful tools for assessing the impact of process improvement and redesign efforts on a regular basis – monthly, weekly, or even daily. In contrast to tables of aggregated data (or summary statistics), which present an overall picture of performance at a given point in time, run and control charts offer an ongoing record of the impact of process changes over time.

An example of a control chart is presented on page 41. This example is drawn from an on-line data management system developed by Quality Data Management, Inc. The graphic shows different data collection points plotted over time for a survey question related to patients’ ability to reach the practice by phone. By measuring and tracking results to this question at regular and frequent time intervals, managers can discern how process improvement interventions relate to changes in survey results. If an intervention appears to have positive results, it can be continued and sustained; if not, it can be modified or discontinued.

Table 7. Example of Goals for an Intervention to Improve Asthma Care
Asthma Population
Monthly Measures and Goals Appropriate for a Collaborative

Measure	Monthly Population Statistic	Typical Levels	Appropriate Goal
Outcome Measures			
Symptom-free days (Incidence of daytime wheeze and nighttime cough in past 2 weeks)	Average for asthma population	<60%	>90%
Functionality measure	Average for asthma population		
Assessment of health status	Percent reporting improvement		
Lost time from work or school	Days per 100 asthma patients		
Balancing Measures			
Emergency department visits for asthma	Percent of asthma population	3-5%	<1%
Asthma hospital days for asthma patients	Total days per 1,000 patients		
Total medical costs per patient	Median of asthma population		10% reduction
Patient satisfaction with asthma care	Percent of patients rating very good	50-80%	>95%
Number of clinic visits	Visits per 100 asthma patients		
Hospital admissions for asthma	Percent of asthma population	>3%	<2%
Patient Behavioral Measures			
Use of self-management plan	Percent of asthma population		
Use of flow meters at home	Percent of asthma population		
Zone-based medication change	Percent of asthma population		
Process Measures			
Treatment with maintenance anti-inflammatory medication	Percent of asthma population	<70%	100%
Written asthma action plan	Percent of asthma population	<50%	>90%
Patients with self-management goals	Percent of asthma population	<50%	>90%
Patients completing assessment tool	Percent of asthma population		
Use of standardized educational materials	Percent of physicians in office		
Source: Adapted from the Institute for Healthcare Improvement's Breakthrough Collaborative College 2001			

Figure 5: Example of a Control Chart

Develop Changes Using Selected Intervention

Depending on the nature of the intervention, you may want to break it down into a set of related but discrete changes. For example, if the team decides to implement a new specialist referral process, you could begin by making changes to the procedures used to communicate with the specialist's office. The communication process with the health plan might then be the target of a separate change.

Conduct Small Tests of Change

Small tests of change help refine improvements by incorporating small modifications over time. Because interventions are tested by one or two staff at a time with just a few patients, you can easily modify them to resolve problems as you receive feedback from patients and/or staff. Look for staff who are open to new ways of doing things to conduct the tests.

Small tests of change are very powerful for several reasons:

- /// They allow for incremental modifications of interventions to fix problems, which helps the larger implementation run smoothly.
- /// You don't have to convince an entire unit or team to try a new idea. New ideas can be quickly tested and then implemented if they prove to be effective with volunteers who are ready to try new strategies.
- /// Failures are low-risk because you have not tried to change the entire culture.
- /// You create enthusiasm and positive "word-of-mouth" for early successes.
- /// It is easier to accumulate evidence for implementation when people are engaged in making something work rather than focused on the "failure analysis".

Example of Implementing a “Small Test”

A Kaiser clinic in Atlanta wanted to implement “doc talk” cards to improve communication with patients (see *Idea C.2: Tools to Help Patients Communicate* in Section 4), but the staff and doctors were resistant, fearing that it would create an even bigger demand for time with the physician. The clinic administrator found one receptionist and one doctor who were willing to pilot the concept.

What They Did: The receptionist gave out index cards to the doctor’s patients and asked them to write down their questions. When the receptionist and doctor realized that patients did not know how to organize their questions, they added topics to the cards (e.g., “Symptoms,” “Medications,” “Tests”) to help patients focus their concerns. In other settings, staff have also used questions, such as, “What are your top three questions for your doctor today?”.

What Happened: The patients and their doctor found this method very helpful at maximizing the time they had in the visit. Word of mouth about the success of this approach spread quickly to the rest of the practice. Soon enough, the other doctors in the practice were knocking on the administrator’s door wanting to use the “doc talk” cards and upset because they hadn’t been invited to try them. The administrator had gained support for the method, resolved problems with the cards quickly, and rolled out the new system in a quarter of the time it usually took to implement changes in the practice.

Adapt Changes to Organizational Context

Most improvement strategies require some adaptation to the culture of the organization. Patient-centered improvement strategies have to take into account the needs of patients and their families as well as the staff. Moreover, front-line staff will frequently resist new ideas if they are not allowed to modify them and test their own ideas.

The adages about “not invented here” and “sometimes you have to do something once so you never do it again” are alive and well in the culture of healthcare. To succeed in implementing improvement strategies, it is wise to let staff adapt change concepts in small tests of change rather than insist they be followed like a recipe.

Identify and Deal with Barriers

As part of its work, the team will need to take a hard look at the psychological, physical, and procedural barriers it has to address in order to accomplish its aim. Barriers to improvement come in many guises. Psychological barriers such as fear of change, fear of failure, or fear of loss of control or power can be significant impediments to overcome. Other common barriers include:

- ⚡ Lack of training in customer service, quality improvement methods, or clinical areas such as doctor-patient communication;
- ⚡ Inadequate staffing levels;
- ⚡ Poor information technology systems; and
- ⚡ Outdated or misguided organizational policies. For example, many organizations are so concerned about violating HIPAA regulations that they do not want to give information to a patient about their *own care* for fear of violating patient confidentiality.

Despite the serious nature of some of these barriers, few are large enough to bring a project to a halt. Typically, they are cited as excuses for two of the fundamental barriers to change: the fear of new ways of doing things and the fear of failure.

The team also needs to identify factors that could facilitate their work. Facilitators can include financial or non-financial incentives, such as gain sharing for staff if a specific target is met or better quality of life for the staff when a problem is fixed. Other facilitators include picking an aim that is part of the organization's strategic plan or one that will improve other goals the staff care about, such as clinical outcomes. Sometimes, the facilitator is the ability of a change to help achieve secondary goals. For example, improvements in doctor-patient communication may decrease medication errors, or the development of shared care plans may improve clinical outcomes and reduce no-shows for appointments or procedures.

Monitor Strategy

Building off of the development and testing of specific changes, the third stage involves implementing the intervention (i.e., the combination of discrete changes) and evaluating progress against the interim measures as well as the goals of the QI project. Did the intervention succeed in reducing the time required to see a specialist? Are members and patients reporting better experiences with regards to getting care quickly? The case example on the next page illustrates how Harvard Pilgrim Health Care tracked and evaluated the impact of one medical group's interventions to improve performance on the "doctor communication" composite.

This part of the improvement cycle is really the ongoing work of health care and where your teams will spend most of their time. There are no set rules about how long this part of the cycle takes. It depends in part on how frequently you monitor your CAHPS scores and other QI measures.

However, it is important not to let the work go on too long without ongoing measurement in order to make sure you are making progress toward achieving your aims. Most monitoring takes place on a monthly to quarterly basis.

Case Example: A Combination of Strategies Improves Performance at Harvard Pilgrim

As described in Section 2 of this guide, Harvard Pilgrim Health Care had decided to focus an intervention on a particular medical group based on its analyses of CAHPS performance at the plan and medical group level. The plan's strategy was to offer the group a financial bonus for achieving targeted performance levels on two composites by 2003.

In response to this incentive, along with other market influences, the medical group went through a process of identifying the factors underlying their performance and designing an ambitious set of interventions to address them. Some of these interventions have been implemented, while others are still in development. Interventions that contributed to performance in the Doctor Communication area include the following:

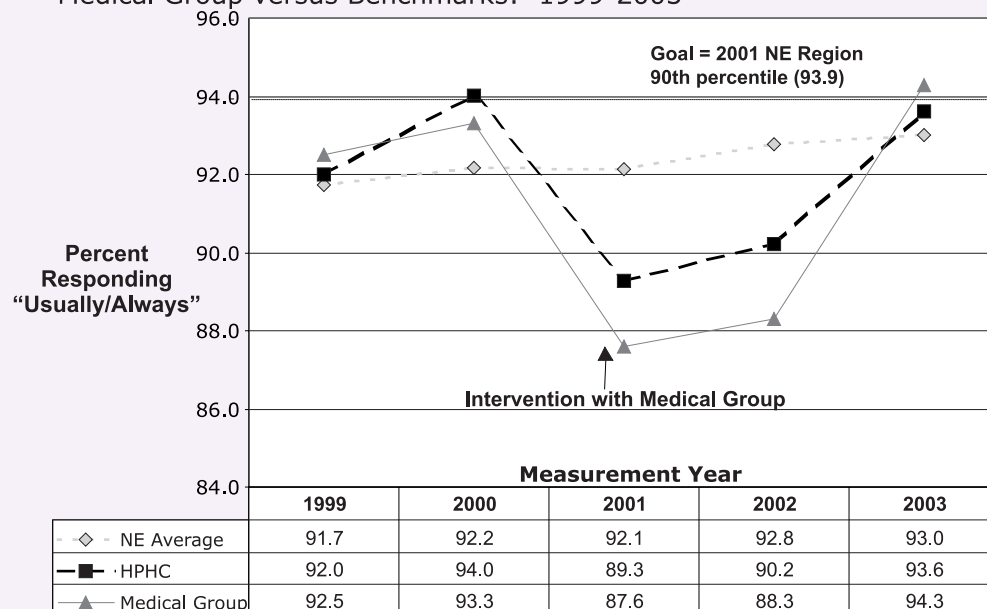
- ⚡ Concerned about disruptions in doctor-patient relationships due to physician turnover and dissatisfaction levels among the physicians (which, according to published studies, are associated with dissatisfaction levels among patients), the group implemented changes designed to improve physician satisfaction and reduce turnover. These changes included different staffing levels, a redesign of the care delivery model, and better practice supports.
- ⚡ To support better physician-patient relationships, the redesign of care delivery also focused on increasing the percent of patients who have a personal relationship with their PCP and their PCP's team (nurse practitioner, OB-GYN). The group transitioned to a different primary care model where patients are much better able to see their own doctor, rather than a practice partner.

As shown in the table below, these interventions have contributed to improvements in the group's performance in the Doctor Communication measures.

In 2003 and 2004, the group is implementing additional practice changes, including online scheduling, open access, email consultation, and a shared patient health record. (See Section 4 for a discussion of these ideas.) Harvard Pilgrim anticipates further improvements in the group's scores over time as a result of these new interventions.

Doctor Communication Composite Top Box Scores Over Time

Medical Group versus Benchmarks: 1999-2003



Source: Harvard Pilgrim Health Care, 2003

Reassess & Respond

The fourth stage of the cycle is the point at which the team reviews the impact of the intervention to see if its goals were met, and conducts a new set of analyses of its CAHPS performance. The purpose of this effort is to get some sense of what worked, what did not work, and what further or new interventions may be needed.

To the extent that the intervention was successful, the team should also be thinking about ways to sustain the improvements over time. One important step that is often neglected is the communication of successes throughout the organization – to organizational leaders as well as clinical and administrative staff. By cultivating discussion of successful projects, the team helps to reinforce the culture of quality improvement, build credibility for the intervention, reward those involved, and foster the spread of effective innovations.

The organization's leaders can also promote the work of specific QI teams through the use of media and through interpersonal communication. Successful innovations can be highlighted in staff newsletters and in staff and board meetings. Leaders can also reinforce the importance of the project by sitting in on QI team meetings or visiting the practice site or unit involved in the project.

A related practice is the communication of changes beyond the walls of the organization to members or patients. By telling people about innovative practices – whether through newsletters, Web sites for members, or handouts in the office – you can raise the standard of expectations.

The Role of Social Interaction in the Spread of Innovation

What's the most effective way to spread a message? Research on the diffusion of innovation has found that social interaction plays a crucial role. Most people do not evaluate the merits of an innovation on the basis of scientific studies; they depend on the subjective evaluations of "early adopters" and model their behaviors after people they respect and trust (Rogers 1995). For that reason, choosing the right team members and opinion leaders is critical to efforts to diffuse innovation.

Opinion Leaders: People within an organization who informally influence the actions and beliefs of others. They are not necessarily people with executive titles.

Depending on the project, you may want to try to identify the opinion leaders that would be helpful to involve (assuming they are open to change and new ideas). Interpersonal communication works best when the people communicating the message are respected opinion leaders within the same staff group whose behavior they are trying to change. For example, an innovation to change the behavior of receptionists will often move quickly if it is lead by a respected receptionist or office manager. This same person would probably not be as effective at getting physicians in a medical group to change their communication style with patients.

Ask people whose opinion they respect. Who do they follow when they have adopted new clinical or improvement practices? Who do your staff look to when they want advice or information about the organization?

Key Resources

Institute for Healthcare Improvement – www.ihl.org

The Institute for Healthcare Improvement (IHI) is a not-for-profit organization driving the improvement of health by advancing the quality and value of health care. IHI offers resources and services to help healthcare organizations make dramatic and long lasting improvements that enhance clinical outcomes and reduce costs. It offers training programs, conferences, publications, conference calls, and opportunities to participate in collaborative projects to improve the delivery of care.

www.improveyourmedicalcare.com – This Web site introduces medical practices to a collaborative program intended to help them assess and improve their ability to deliver high-quality care, particularly to patients with chronic diseases. The training program is sponsored by the Dartmouth Hitchcock Medical Center and the Institute for Healthcare Improvement (IHI).

Recommended Reading on QI Techniques

Carey RG, Lloyd RC. *Measuring Quality Improvement in Healthcare: A Guide to Statistical Process Control Applications*, New York: American Society for Quality, 1995.

Plsek P. Tutorial: Introduction to Control Charts, *Quality Management in Healthcare*, 1(1), 65-74, 1992

Plsek P. Tutorial: Planning for Data Collection, Part II- Designing the Study, *Quality Management in Healthcare*, 2(4), 73-81, 1994

Plsek P. Tutorial: Planning for Data Collection, Part III- Sample Size, *Quality Management in Healthcare*, 3(1), 78-92, 1994

Wheeler D. *Understanding Variation: Keys to Managing Chaos*. Knoxville, Tennessee: Statistical Process Controls, Inc., 1993.

Recommended Reading on the Dissemination of Innovative Practices

Rogers E. *Diffusion of Innovations*. New York: The Free Press, 1995.

Gladwell M. *The Tipping Point*. Boston, Massachusetts: Little, Brown, and Company, 2000.

Section 4: Things You Can Do to Improve Your CAHPS Scores

As the third section of this guidebook explains, one of the first tasks of the QI team is to identify strategies with the potential to address any weak spots in CAHPS-related performance. To give you a head start, this section presents over 20 ideas for improving the patient's and consumer's experience of care as measured by the CAHPS surveys. The descriptions in this section are intended to give you enough information to determine whether the strategy is pertinent and worth further investigation. Specifically, they should help you to develop a better understanding of the following:

- /// The strategy's connection to the patient's or member's experience with health care services
- /// Its goals and likely benefits
- /// Barriers to its implementation
- /// Its impact (when possible)

In addition, the guidebook provides a list of pertinent resources, including books, Web sites, and journal articles, that you can consult for more information.

These ideas represent a range of possible solutions. Some are easy and inexpensive to implement, while other are much more logistically complex and require a significant investment of money, resources, and time. If you find a strategy that seems appropriate but overwhelming, it's fine to "start small" — perhaps by tackling one component of the strategy, or even by stepping back to assess your organization's readiness for the change. In addition, some strategies are likely to address the performance issue directly, while others may have an indirect impact. Some may allow you to see results right away, whereas others may take months or even years to make a measurable difference.

As you review your options, consider the immediate and long-term goals of your organization, as well as its constraints. You may also want to explore ways to stage the implementation of one or more strategies to make them more feasible.

Perhaps most importantly, these strategies are directed at two different stakeholders: health plans and medical groups. As discussed in the introduction to this guidebook, both the plan and the medical practice can contribute to performance on each of the CAHPS Health Plan Survey composites, but primary responsibility can be assigned to one or the other. One way to think about this is that both are in the "car," but one is the driver and the other is a passenger — helping to navigate but not at the wheel.

Thus, both health plans and provider groups have to make changes to improve patients' experiences with a given aspect of care, even though one may be more "responsible" than the other for that element of health care services. Health plans, for example, often play an important role in equipping providers with the skills and tools they can use to improve communication with patients — even though it's the provider who does the communicating.

In the table on the next two pages, you can see which strategies are most appropriate for each set of stakeholders ("1" indicates primary responsibility; "2" indicates secondary responsibility). When you turn to the individual descriptions, look for a round icon that indicates who is expected to participate in the strategy. If both plans and groups are involved, the one likely to take on primary responsibility for design and implementation is indicated in **bold type**.

How the Ideas Are Organized

The improvement strategies are grouped into six headings that represent the five CAHPS reporting composites as well as the supplemental items for HEDIS and Medicare beneficiaries:

- /// Getting Needed Care
- /// Getting Care Quickly
- /// How Well Doctors Communicate
- /// Customer Service (combines two composites—Courteous and Respectful Office Staff and Health Plan Customer Service—with the HEDIS items about complaints)
- /// Claims Processing (from CAHPS 3.0H, the HEDIS version of the CAHPS Health Plan Survey)
- /// Home Health and Preventive Services

The following table is designed to help you find the strategies most likely to address the performance weaknesses you identified by analyzing your CAHPS data. It lists each of the CAHPS items (by topic) and indicates which strategies you might want to consider and whether the strategy is more appropriate for health plans or provider groups (“1” indicates primary responsibility for design and implementation; “2” indicates secondary responsibility). When you turn to a set of related strategies, you will see the full CAHPS questions.

Table 8. An Index of Improvement Strategies

Composite and Short Title of Item	Locus of Accountability		Relevant Strategy	Page No.
	Health Plan	Provider Network		
A. Getting Needed Care				
Problem getting a personal doctor	❶	—	Beyond-the-Basics Provider Directory	54
Problem getting referral to a specialist	❶	—	Beyond-the-Basics Provider Directory	54
	❷	❶	Rapid Referral Programs	57
Problem getting needed care	❷	❶	Rapid Referral Programs	57
Problem with delays in care because waiting for health plan approval	❷	❶	Rapid Referral Programs	57
B. Getting Care Quickly				
Got help or advice by phoning clinic	❷	❶	Access to Email	70
	❶	❷	Internet Access	75
	❷	❶	Standards for Customer Service	119
Got routine appointment as soon as wanted	—	❶	Open Access Scheduling	62
Got needed care right away	—	❶	Open Access Scheduling	62
	—	❶	Streamlined Patient Flow	68
Taken to exam room within 15 minutes	—	❶	Streamlined Patient Flow	68

Composite and Short Title of Item	Locus of Accountability		Relevant Strategy	Page No.
	Health Plan	Provider Network		
C. How Well Doctors Communicate				
Doctors listen carefully	❶	❷	Training Physicians to Communicate	82
	—	❶	Group Visits	104
	❷	❶	Tools to Help Patients	86
	❷	❶	Shared Decision Making	91
Doctors explain things clearly	❶	❷	Training Physicians to Communicate	82
	—	❷	Group Visits	104
	❶	❷	Evidence-based Information	97
	❶	❷	Support Groups/Self Care	95
	❶	❷	Shared Decision-Making	91
Doctors respected your comments	❶	❷	Training Physicians to Communicate	82
	❷	❶	Tools to Help Patients	86
	❷	❶	Shared Decision Making	91
Doctors spent enough time	—	❶	Group Visits	104
	❶	❷	Evidence-Based Information	97
	—	❶	Planned Visits	102
D. Customer Service				
Courteous and Helpful Office Staff				
Doctor’s staff courteous and respectful	—	❶	Listening Posts	109
	—	❶	Service Recovery	114
	—	❶	Patient/Family Councils	112
	—	❶	Standards for Customer Service	119
Doctor’s staff helpful	—	❶	Listening Posts	109
	—	❶	Service Recovery	114
	—	❶	Patient/Family Councils	112
Health Plan Customer Service				
Problem finding or understanding written information	❶	—	Listening Posts	109
	❶	—	Claims Processing	125

Composite and Short Title of Item	Locus of Accountability		Relevant Strategy	Page No.
	Health Plan	Provider Network		
Health Plan Customer Service (<i>continued</i>)				
Problem getting help from customer service	❶	—	Listening Posts	109
	❶	—	Service Recovery	114
	❶	—	Claims Processing	125
Problem with paperwork	❶	—	Claims Processing	125
Additional CAHPS 3.0H Questions				
Claims handled in reasonable time	❶	—	Claims Processing	125
Claims handled correctly	❶	—	Claims Processing	125
Amount required made clear	❶	—	Claims Processing	125
How long to resolve complaint	❶	—	Service Recovery	114
Complaint settled satisfactorily	❶	—	Service Recovery	114
E. Home Health and Preventive Services				
Problems with home health services	❶	—	Innovative Home Health Services	130
Had mammogram	❶	❷	Reminder Systems	132
Had prostate screening	❶	❷	Reminder Systems	132
Exercising 20 minutes	❶	❷	Reminder Systems	132
Had flu shot	❶	❷	Reminder Systems	132
Had pneumonia shot	❶	❷	Reminder Systems	132

What's Not Here

Of course, there are many things beyond the scope of QI initiatives that health plans and medical groups can do to raise their CAHPS scores. Examples include increasing the size of the provider network and redesigning or enhancing the physical plant and facilities in which consumers and patients are treated. These kinds of strategies are not discussed in this Guidebook.

A Recurring Theme: Information Technology in a Supporting Role

A quick review of the list of strategies reveals information technology (IT) at the center of various efforts to improve consumers' and patients' experiences with care. However, this does not mean that technology is the answer to all of your problems, nor does it mean that you must rely on technology to improve the quality of care. Information technology is a valuable tool for facilitating communication, expediting care, and increasing efficiency – but it also introduces complexity and costs that you must be prepared to handle.

If you decide to harness information technology as a means of improving care, take the time to consider how the technology fits with the larger IT strategy of your organization. With the help of an IT specialist, either as part of the QI team or as a consultant, the team needs to determine what they need the technology to do, whether existing (i.e., in-house) systems can meet those needs, and if not, how a new technology would be integrated with those existing systems. Perhaps more importantly, the team needs to make sure that all stakeholders accept the strategy underlying the technology. In many cases, a new system has been deemed a failure not because of the technology but because the “users” had not bought into the intervention. If the culture is not ready for change, new technologies will invariably fail.

Recognizing that health care organizations adopt expensive new technologies for many reasons, the CAHPS QI team should pay attention to the potential benefits of these systems from the patient's or member's perspective, and make sure that those benefits are realized. Electronic data interchange (EDI), for example, is typically regarded as a way to reduce transaction costs by sharing information among providers and insurers electronically. Rather than sending paper back and forth, EDI allows health care organizations to exchange data with insurers in seconds rather than hours or even days or weeks, resulting in cost savings for the plans and providers. But these cost savings do not capture the benefits to patients, such as faster approvals for specialty care and more accurate information about claims.

Example of EDI in Practice

In New England, a group of plans and health systems developed a network called the New England Health EDI Network (NEHEN), which facilitates rapid Internet-based approval from insurers and greatly reduces transaction costs. NEHEN has resulted in substantial cost savings to the participating health care networks. For Caregroup, the cost per authorization request went from \$4.74 (for requests by phone, paper, etc.) to 15 cents; for Partners Healthcare System, the cost dropped from \$2.64 to 10 cents (Pizzo 2002).

Electronic medical records (EMRs) are another excellent example of a technology with the potential to vastly improve the experiences of members and patients with health care services. While EMRs are primarily designed for the use of medical personnel, they can be made accessible to patients via the Internet. To many people, EMRs offer the best hope of improving coordination of care among primary care doctors, specialists and the patient. They can also be linked with new systems that are providing evidence-based, customized clinical information directly to patients (for more on this topic, see *Idea B.4: Internet Access for Health Information and Advice* and *Idea C.5: Delivery of Evidence-Based Information*).

A number of health care and consumer organizations are advocating an approach to EMRs that would enable patients (rather than health care organizations) to control access to personal electronic records. For more information about this initiative, contact the Patient Safety Institute (www.ptsafety.org).

Section 4-A

Improvement Strategies for “Getting Needed Care”

This section presents two ideas intended to make it easier for consumers to choose a personal provider that meets their needs and to get prompt access to other sources of care, including specialists. These strategies include:

1. Beyond-the-Basics Provider Directories
2. Rapid Referral Programs

They focus on performance issues raised by the “Getting Needed Care” composite, which is composed of the following CAHPS questions:

CAHPS Questions in the “Getting Needed Care” Composite

- ⚡ With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?
- ⚡ In the last...months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?
- ⚡ In the last...months, how much of a problem, if any, was it to get the care you or a doctor believed necessary?
- ⚡ In the last...months, how much of a problem, if any, were delays in health care while you waited for approval from your plan?



A.1 Beyond-the-Basics Provider Directories

The Problem

An analysis of responses to the 2002 Medicare Managed Care CAHPS survey found that, on average, nearly a quarter of enrollees experienced some problem finding a primary care provider (doctor or nurse) who could meet their needs (see Table 9 below.) For commercial health plan enrollees, the situation is worse. According to data from NCQA, in 2001, 35 percent of members on average reported a problem finding a provider. And for the plans in the bottom 10th percentile, 45 percent of members reported a problem (NCQA 2002).

**Table 9. Problems Getting a Personal Provider:
The Experiences of Medicare Managed Care Enrollees**
Percent of Respondents Reporting No Problem Getting a Personal Doctor or Nurse*

Year	Mean	10th Percentile	25th Percentile	Median Percentile	75th Percentile	90th Percentile
2000	78.85	69.31	74.75	79.67	84.25	87.08
2001	75.72	65.03	71.00	75.80	81.52	86.41
2002	77.16	65.93	71.57	78.16	83.54	87.31

* Question: With the choices your Medicare plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

Source: Medicare Managed Care CAHPS Survey

To find a personal provider, health plan members generally rely on a provider directory that indicates which doctors, hospitals, and other health care providers are available to them. These directories typically provide the name and contact information for each provider, often organized by location and type of practice. Some also include the hospital affiliation of the doctor, office hours, and languages spoken. Members usually receive a printed provider directory upon enrollment, when they may be asked to choose a primary care provider from the published list. Plans update their directories on a regular basis, to keep current with changes in the provider network.

One problem with this standard approach to directories has been that the printed versions often could not keep up with changes in the network. Members would contact a provider only to find that she was no longer in the network, or would not know of the availability of a provider new to the network. Another issue has been that few directories offer information that can help members figure out which provider would be most appropriate for their needs. This has complicated the process of finding a provider that a member can be “happy with;” some remain unhappily loyal to their initial uninformed choice, while others try out multiple providers looking for the one that suits them.

Primary care physicians (PCPs) also need good information in order to choose the right specialist for a patient. While they may know some specialists through various channels, they frequently face the same problem that members have when trying to choose a primary caregiver, i.e., they lack the data needed to make an informed decision.

The Intervention

In the past decade, methods for organizing and publishing provider directories have evolved rapidly, incorporating new content as well as new delivery mechanisms. For example, some sophisticated directories now include expanded information on the providers in the network, such as personal profiles of providers (background and training, board certification, practice philosophies, photographs) and comparative quality and performance ratings (based on patient survey data, clinical data, or both). To see Web sites where patients can post information about a physician, go to: www.HealthGrades.com and www.TheHealthPages.org.

Some are also taking advantage of new technologies to improve members’ access to up-to-date directory information. While printed directories are still common, many health plans have launched Internet-based directories to provide members with access to information on-line. Web-based directories allow members to search for providers by benefit plan, location, and specialty. They can also include direct links to providers’ Web sites, making it easier for members and patients to obtain detailed information on physician practices, such as office hours, languages spoken, and maps showing where the office is located.

These innovations in provider directories can enhance ease of patient and enrollee access to appropriate caregivers. Improved access to information about providers can in turn improve member relations as well as provider-patient relationships. Finally, expanded provider directories can also be a helpful resource for PCPs seeking to make a good “match” between patients and specialists.

Some Examples

HealthPartners: One example of an innovative on-line provider directory tool is the HealthPartners’ Consumer Choice System (<http://www.consumerchoice.com>). This system allows both members and non-members to log in and search for providers and clinics in the HealthPartners network by zip code, as well as to compare the quality of clinics using measures of clinical quality as well as consumers’ reports on their experiences with

Results of a Low-Tech Intervention

Enhancements to the provider directory do not require a Web address to be successful. For example, after reviewing member survey results, a mid-sized health plan decided to address its members’ dissatisfaction with the process for choosing a primary care physician. By reviewing complaints, the plan learned that one problem was the requirement that members contact physicians themselves to make sure they were accepting new patients.

What They Did: To deal with this problem, the plan initiated a new process: Three times a year, it asked its PCPs to verify whether they would accept patients for the next four months. Based on that information, the plan updated and printed a new provider directory every four months. Because the directories were current, patients were no longer required to call the primary care provider’s office prior to selecting the provider.

What Happened: This intervention resulted in a one-year increase in the percentage rating the “ease of choosing a personal physician” as either very good or excellent from the baseline of 41 percent to 48 percent. Further interventions to facilitate the process of changing physicians (including the use of a tear-out, postage-paid card in the directory that members could use to notify the plan when selecting or changing providers) boosted the rate to 55.4 percent over two years. Subsequent interventions, including the addition of the provider directory to the plan’s Web site, resulted in further improvements in the score (NCQA 2001).

care. A special feature of the performance comparisons, called “People Like Me,” presents information on quality of care for specific medical conditions, such as diabetes, or types of people, such as children or adults.

PacifiCare: PacifiCare Health Systems’ Doctor Directory (www.pacificare.com) is an on-line directory available to members and non-members that allows them to identify contracted providers by health plan product, type of providers, and location. Special features allow users to customize their search by distance, specialty, and language preference. The PacifiCare Web site also features the *Quality Index*® profile, a public report on medical group performance. The index rates medical groups and IPAs that contract with PacifiCare on more than 40 measures related to clinical and service quality, affordability, and administrative accuracy.

Key Resources

Stone EM, Heinold JW, Ewing LM, Schoenbaum, SC. *Accessing Physician Information on the Internet*. Pub. #503. New York, NY: Commonwealth Fund, January 2002. Available at:

http://www.cmwf.org/programs/quality/stone_mdinternet_bn_503.asp

This study of 40 physician directory Web sites found that many of the sites suffered from incomplete physician listings, few search options, and missing, inaccurate, or outdated data. Few Web sites provided information on disciplinary actions, malpractice claims, or mortality rates. And few offered e-patients an opportunity to review or rate their doctors.

National Committee for Quality Assurance (NCQA). With funding from the Commonwealth Fund, NCQA has developed recommendations for elements that health plans should include in their provider directories. A report entitled “Recommendations for Improving the Quality of Physician Directory Information” is available. Please contact Linda Shelton (shelton@ncqa.org; 202 955-5165) for more information.

WebMD (www.webMD.com). In addition to general health information, WebMD includes a “Find a Doctor” section. The format of this information offers health plans and care systems a model for providing an on-line physician directory.

A.2 Rapid Referral Programs

The Problem

Both the ease and the speed of the specialist referral process are major concerns for patients and their primary care providers. For patients, problems getting a referral are reason enough for dissatisfaction. Patients having trouble getting referrals reported the greatest level of distrust, lack of confidence, and dissatisfaction with their PCP (Grumbach, Selby et al. 1999).

Compounding their frustration is the possibility of delays in care, which generates greater anxiety and contributes to a greater risk of adverse clinical outcomes (Murray 2002). This problem is especially salient for members with chronic illnesses, who typically require regular visits with one or more specialists.

In addition, patients unclear on the process or disconcerted by the wait often have little choice but to call their clinician’s office to seek clarification and assistance, which can add to their frustration (and increases the workload for the office). Some patients end up seeking care elsewhere (e.g., emergency departments and urgent care clinics), and become “no-shows” for the eventual referral appointment.

Specialist referrals are a serious problem for some health plan members. Among Medicare managed care enrollees surveyed in 2002, about 20 percent reported a problem seeing a specialist when needed (see Table 10 below.) Similarly, nearly one quarter of commercial health plan enrollees reported a problem getting a referral to see a specialist. Among the plans in the lowest percentile of performance, roughly a third of the members reported either a small or big problem (NCQA 2002).

**Table 10. Problems Getting a Specialist Referral:
The Experiences of Medicare Managed Care Enrollees**

Percent of Respondents Reporting No Problem Getting a Specialist Referral *

<i>Year</i>	<i>Mean</i>	<i>10th Percentile</i>	<i>25th Percentile</i>	<i>Median Percentile</i>	<i>75th Percentile</i>	<i>90th Percentile</i>
2000*	83.71	75.32	80.00	84.55	88.69	91.51
2001**	80.48	72.07	76.14	81.90	85.53	88.31
2002**	79.95	69.94	75.78	81.15	85.29	87.82

* Question in 2000: In the last 6 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?

** Question in 2001 and 2002: In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?

Source: Medicare Managed Care (MMC) CAHPS Survey

While several factors contribute to complaints about specialist referrals, one common problem is that physicians' offices are not set up to handle the referral process efficiently. In particular, they are not communicating well with the specialists, the health plans, or their patients.

Intervention#1: The Referral Agreement

Rapid referral programs include a host of strategies intended to reduce the delays associated with specialty referrals and increase satisfaction among patients and doctors. One useful approach is to improve communication between the PCP and the specialist through a referral agreement.

The goals of a referral agreement include the following:

- ⚡ Speeding the process by which a PCP makes a referral to a specialist
- ⚡ Reducing the amount of time between the initiation of a referral and the date of the patient's appointment with the specialist
- ⚡ Providing the PCP with decision support for the referral decision (typically in the form of guidelines)
- ⚡ Improving the flow of information among the PCP, the specialist, and the patient

When implemented effectively, this program should result in earlier diagnoses, reduced "no-show" rates at specialists, better patient outcomes, and greater patient satisfaction.

The referral agreements is meant to make the process more systematic and more responsive by helping PCPs make appropriate referral decisions and clarifying the expectations for information on both ends. In general, referral agreements require the following elements (Murray 2002):

"Patients are often informed that they will be 'referred' but have little or no influence on the process or knowledge about who they will be referred to or how long the expected wait will be."

(Murray 2002)

Delays Due to Preauthorization: A Decreasing Problem

In the 1990's, referral problems were primarily regarded as the responsibility of health plans, many of which had policies and practices in place that caused delays in referral authorizations. However, it appears that various changes in these policies and practices – including direct access to OB/GYNs and other "repeat" specialists and more efficient systems for processing referral request — have succeeded in minimizing delays. The NCQA reports that even in the lowest performing plans, nearly three-quarters of members report no problems with delays due to health plan approvals (NCQA 2002).

For more information on some of the strategies that health plans have adopted, see the following case studies in the NCQA's Quality Profiles (www.qualityprofiles.org):

- ⚡ Decreasing Complaints and Appeals Regarding Referrals: Addressing Opportunities for Improvement
- ⚡ Improving the Referral Process: Changing the System to Boost Satisfaction
- ⚡ The Referral Process: Reengineering Referrals to Improve Satisfaction
- ⚡ Referral Redesign: Partnering with Vendors

1. Joint development of guidelines by a small group of PCPs and specialists who are willing to think of themselves as creating a cohesive system of care. The purpose of the guidelines is to identify which clinical conditions the PCPs should manage themselves and which should be referred to the specialists.
2. An explanation of the benefits to PCPs (e.g., shorter waiting times for patients, more timely and complete information from the specialist). While specialists may get fewer referrals, the benefits to them are more obvious: more effective care for patients, higher relative value units (RVUs), and more referred patients who have had a complete work-up.
3. A referral process that involves the patient in decision making. This process should be designed to keep the patient informed, identify the work-up required before the specialist appointment, inspect the completeness of the work-up, and make sure that both the specialist and the PCP receive timely information. An electronic referral system can facilitate this process.
4. An evaluation of the new referral process based on specific measures, such as waiting time for an appointment, physician compliance with the guidelines, and patient satisfaction with involvement in the referral process.

An Example

An example of an electronic referral system can be found at The University Hospitals of Leicester, England, which have embarked on a pilot of a Web-based electronic referral system for cancer. While this project applies to the UK’s National Health System, which clearly differs in many ways from the system of care in the U.S., it is still illustrative of the improvements that technology can make, in this instance by linking decision support with an electronic referral process.

When the clinician opens the Early Referrals Application (ERA), he or she chooses from among 12 different cancers, and then selects the electronic referral option. Once there, the physician is guided through a series of three screens:

- /// **Data entry:** This page collects the information needed for the decision support module (e.g., for breast cancer, it has a series of check boxes to describe lumps, skin changes, pain, etc.).
- /// **Recommendations:** Using the data entered in the first screen, this page indicates whether a referral is recommended and, if appropriate, the degree of urgency. If the physician chooses the “referral” button, the final screen appears.
- /// **Referral form:** This form captures the patient information needed by the specialist being given the referral. Because of the link to an electronic medical record system, much of the demographic information will already be inserted. When the physician adds additional comments or notes and clicks on “Email Referral,” the form is sent to the referral hospital.

More information about this project is available at <http://www.infermed.com/era>.

Intervention #2: The Referral Expert

Doctors and group practices that care for patients covered by multiple plans and insurers often expend a great deal of time and energy getting approvals from the plan/insurer for referrals to specialists, hospital admissions, tests, and procedures (Preston 1999). This task has become increasingly complex as the number of insurance products has grown, since each one has its own rules and requirements.

One way to address this problem is for a group practice to develop a “referral expert” – in the form of a person, a computer system, or a combination of the two – that is responsible for tracking and managing each plans’ requirements. This basic strategy helps to increase the speed of approvals, which has multiple benefits. For the patient, it can mean reduced or eliminated delays for referrals, tests, and procedures, which increases satisfaction with care (Chan, Hayden et al. 1997). For providers, health plans, and payers, quicker approvals save costs associated with the phone and paper-based approval processes (NEHEN 2002), as well as costs resulting from grievances and complaints.

A referral expert would expedite insurance authorization by doing the following (Preston 1999):

- ⚡ Knowing which plans require authorizations
- ⚡ Staying abreast of changes in plan regulations
- ⚡ Knowing what actions to take when referrals are denied

However, this intervention can be as simple as developing matrices (or ideally, a database) of referral requirements, copays, etc., for each insurance product and designating a person to keep the matrix or database up-to-date.

Other Interventions to Consider

In addition to becoming familiar with each plan’s requirements, medical groups may want to explore other ideas for managing referrals more effectively, such as:

- ⚡ Standardizing referral forms across multiple plans;
- ⚡ Developing forms that specialists’ offices can fill out so that the PCP has all the information needed to get preauthorization.
- ⚡ Hiring a referral coordinator who can keep track of all referral requests and follow-up items, and facilitate communication with patients, specialists, and plans.

For more information on these ideas, see: Spicer, J. Making Patient Care Easier Under Multiple Managed Care Plans. *Family Practice Management*. February 1998. <http://www.aafp.org/fpm/980200fm/spicer.html>. Accessed May 6, 2003.

Key Resources

Murray M. Reducing waits and delays in the referral process. *Family Practice Management* March 2002. 9(3): 39-42.

Ghandi T, Sittig D, Franklin M, et al. Communication breakdown in the outpatient referral process. *J Gen Intern Med*. 2000;15:626-631.

Van Es G. Improving the referral process: one group’s experience with CQI. *Family Practice Management*. May 1997.

For information on the Early Referrals Application, see:

- ⚡ National pilot to reduce cancer waiting times. London, 7th September 2001. <http://www.infermed.com/pr010907.htm>, accessed 8/12/02

For information on related projects sponsored by the National Health Service in the UK, see the following documents on www.nhs.uk.

- ⚡ Electronic referrals aim to reduce waiting time for patients with suspected cancer
- ⚡ Pilot objectives

Section 4-B

Improvement Strategies for “Getting Care Quickly”

This section presents four ideas for expediting the delivery of care to patients and consumers:

1. Open Access Scheduling for Routine and Urgent Appointments
2. Streamlined Patient Flow
3. Access to Email for Administrative Help and Clinical Advice
4. Internet Access for Health Information and Advice

These ideas focus on performance issues raised by the “Getting Care Quickly” composite, which includes the following CAHPS questions:

CAHPS Questions in the “Getting Care Quickly ” Composite

- ⚡ In the last...months, when you called during regular office hours, how often did you get the help or advice you needed?
- ⚡ In the last...months, how often did you get an appointment for regular or routine health care as soon as you wanted?
- ⚡ In the last...months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?
- ⚡ In the last...months, how often did you wait in the doctor’s office or clinic more than 15 minutes past your appointment time to see the person you went to see?



B.1 Open Access Scheduling for Routine and Urgent Appointments

The Problem

While most Medicare managed care enrollees (about 90 percent) report that they always or usually receive care as soon as they wanted it (see Table 11 below), studies have shown that inadequate access to a primary care provider remains a major source of patient dissatisfaction (Forjuoh, Averitt et al. 2001). Among commercial health plan enrollees surveyed in 2001, only three-quarters reported that they received non-routine care as soon as they wanted. Also, on average, only two-thirds of those who needed non-routine care were seen the same day or the next day (NCQA 2002).

**Table 11. Getting Care As Soon as It’s Wanted:
The Experiences of Medicare Managed Care Enrollees**
Percent of Respondents Reporting that They Always or Usually Received Care
As Soon as They Wanted *

Year	Mean	10th Percentile	25th Percentile	Median Percentile	75th Percentile	90th Percentile
2000	90.89	84.92	88.33	91.76	94.26	95.96
2001	91.48	85.71	89.04	92.49	94.86	96.48
2002	90.80	82.95	87.84	92.31	94.87	96.40

* Question: In the last 6 months, when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?

Source: Medicare Managed Care (MMC) CAHPS Survey

Several studies cited in a recent JAMA article confirm that patients are not getting the care they need when they need it (Murray and Berwick 2003):

- /// In a survey of insured adults under 65, 27 percent of those with health problems reported difficulty gaining timely access to a clinician.
- /// From 1997 to 2001 the percentage of people reporting an inability to obtain a timely appointment rose for 23 percent to 33 percent.
- /// In 2001, 43 percent of adults with an urgent condition reported that they were sometimes unable to receive care as soon as they wanted.
- /// 28 percent of women in fair or poor health reported delaying care or failing to receive care because of an inability to obtain a timely physician appointment.

The Intervention

Open access³— also known as advanced access and same-day scheduling — is a method of scheduling in which all patients can receive an appointment slot on the day they call, almost always with their personal physician. Rather than booking each physician’s time weeks or even months in advance, this model leaves about half of the day open; the other third is booked only with clinically necessary follow-up visits and appointments for patients who chose not to come on the day they called (typically no more than 25 percent of patients).

³ “Open access” sometimes refers to the elimination of gatekeepers in HMOs so that patients have direct access to specialists. In this context, it refers only to same-day appointments.

This model breaks away from the traditional approach of differentiating between urgent and routine appointments, which results in the routine visits being put off until a later date. Instead of triaging callers by clinical urgency, front-desk staff simply sort the demand for appointments by clinician. According to experts in the design and implementation of the model, it is effective in both managed care and fee-for-service environments (Murray and Tantau 2000).

“It has one very simple yet challenging rule: Do today’s work today.”

(Murray and Tantau 2000)

In essence, the open access model applies the principles of queuing theory and industrial engineering in an effort to match the demand for appointment visits with the supply (i.e., the time of clinicians). It is based on the supposition that the problem is not lack of capacity but an imbalance between supply and demand.

While the open access model has not yet been formally evaluated with systematic controlled studies (Murray, Bodenheimer et al. 2003), anecdotal evidence points to several benefits of this approach:

- ✦ It enables practices to reduce or eliminate delays in patient care without adding resources. Better access to care typically results in higher levels of patient satisfaction; physician satisfaction also improves as long backlogs and angry patients are no longer a daily source of frustration (Murray and Tantau 1998).
- ✦ In contrast to what many physicians anticipate, patient demand for appointments decreases, mostly because patients are more often able to see their own clinician (Murray and Berwick 2003).
- ✦ The ability of patients to see their personal physician enhances continuity of care, which is associated with both better health care and higher patient satisfaction.
- ✦ Finally, medical practices often realize cost and efficiency savings. Because patients no longer have to deal with long waits, the number of “no-shows” is likely to decrease, so clinical time is used more efficiently. Also, less staff time is required to manage the no-shows and the backlog of patients.

How Open Access Differs From the Carve-Out Model

The carve-out model incorporates aspects of both the traditional approach to scheduling and the open access model. In the carve-out model, capacity is increased by reserving some appointment slots open each day in anticipation of the need for urgent care. However, this model suffers from many of the same problems as the traditional approach because routine visits are still put off for another day, creating the same stresses on the scheduling system (including an unmanageable backlog of non-urgent appointments) as well as other problems. (Murray and Berwick, 2003)

The literature on open access suggests that medical practices can implement this model in a few months by working through the following steps:

1. Measure supply and demand as precisely as possible. (See below for more on the challenges of predicting demand.)
2. Establish a test team of providers who are willing to try the system out.
3. Reduce the backlog of appointments. This may take six to eight weeks of extra work. To facilitate this difficult task, practices may want to set a target date and agree that visits will not be pre-scheduled beyond that date. Another useful recommendation is to apply the

concept of “max packing.” The idea is to reduce the demand for future visits by taking care of any upcoming preventive or screening needs whenever the patient comes in for a necessary visit – regardless of the reason for that visit.

4. Simplify the appointment types and make them all roughly the same length. One recommended tactic is to minimize complexity by limiting the practice to three appointment types:

- Personal, where the patient is seeing his or her physician;
- Team, where the patient is seeing someone else on the clinical team; and
- Unestablished, where the patients does not yet have a specific physician.

Appointment times can also be specified as either short or long, where a long appointment is roughly equivalent to two short ones (Murray and Tantau 2000).

Develop a contingency plan for days (or parts of the day) when demand far outstrips the availability of physicians. This plan should identify who can supplement or substitute for each physician, if and when needed. Also, the group should be proactive about planning for those times when they can predict increases in demand, such as visits for school physicals or flu shots.

5. Reduce demand for one-on-one visits with patients. One helpful tactic is to identify and address sources of unnecessary visits based on outdated clinical protocols, such as routine follow-up visits for urinary tract infections or annual Pap smears. Another approach is to implement group visits to better manage care for patients with the same chronic condition. (See the description of *C3: Group Visits*.) Finally, clinicians can use the phone and email effectively to address concerns that do not require a visit.
6. Once the practice is able to offer same-day appointments, it should assess its effectiveness by measuring appointment availability on a daily basis (e.g., third next available appointment). (For more information on the specific measures that you can use to evaluate and monitor the model, see the February 2003 JAMA article by Mark Murray and Donald Berwick cited in the box listing Key Resources.)

While the implementation of open access scheduling may seem daunting, the primary barriers are psychological rather than logistical. For both clinicians and their staff, this approach seems unintuitive; it defies both their beliefs and their experiences with scheduling systems. Because routine and urgent requests are treated similarly, the model also forces them to abandon the solidly ingrained notion that routine care can wait. Finally, clinical and administrative staff are typically skeptical that existing resources can meet demand (Murray and Berwick 2003).

That said, the logistical challenges should not be discounted. First, the model requires accurate data on the size of the patient population (for each doctor), the level of demand for visits, and the number of appointment slots available each day. In particular, it relies on the ability to accurately predict demand for same-day appointments (Forjuoh, Averitt et al. 2001). But demand is hard to measure retrospectively because the number of past appointments is more a factor of the supply of clinical time than of the demand for services. Medical groups need to obtain this data prospectively, usually by tracking patients’ calls for appointments as well as requests by clinicians for follow-up appointments. Some practices rely on mathematical models for predicting demand, with mixed success (see box below). Computer-based information systems that integrate billing and scheduling can be useful for providing the initial data input for such models (Forjuoh, Averitt et al. 2001).

An Example of the Challenge of Predicting Demand

One of the biggest challenges in open access scheduling is predicting daily, weekly, monthly, and seasonal demand for same-day appointments. Forjuoh et al. compared the accuracy of two demand prediction grids (estimates of demand for future same-day appointments) for the Scott and White Killeen Clinic. One grid was created by the Scott and White Killeen Clinic itself; the other was an “off-the-shelf” grid developed by Kaiser Permanente for the Clinic. In a six-month period, the Scott and White Killeen Clinic had 6 percent more appointments, on average, than its own demand grid had predicted. While Kaiser Permanente’s grid was relatively accurate in its predictions of the Scott and White clinic’s demand, it was less accurate at predicting seasonal fluctuation in demand (Forjuoh, Averitt et al. 2001).

The second major challenge is reducing the backlog of appointments. To do this, the group may need to see more patients each day for six to eight weeks (Murray 2000). A recent study of practices that have implemented open access scheduling found that all of them had trouble working down the backlog. Moreover, the task was especially difficult for larger organizations, especially when the model was introduced by management rather than by the physicians themselves. One contributing factor was that management recognized benefits in the form of reduced delays in appointment before the physicians saw benefits in the form of a less stressful workday (Murray and Berwick 2003).

Finally, there are some practices where the demand for appointments vastly exceeds the supply of clinical services. While the open access model can handle excess demand on a given day, no scheduling system works effectively if demand is greater than capacity on a permanent basis.

To overcome both the psychological and logistical barriers, medical groups may want to join a collaborative, where they can learn from others dealing with the same issues, or hire a consultant who can guide them through the more challenging terrain. For example, PracticePartners – a practice management company in Portland, Maine – started out by having one of its primary care clinics participate in the Institute for HealthCare Improvement (IHI) collaborative on improving efficiency and access. Once that clinic had some success with the strategy, PracticePartners developed an internal collaborative so that other practices could learn from the experiences of the first clinic.

Some Examples

In the late 1990’s, HealthPartners of Bloomington, Minnesota, identified members’ dissatisfaction with access to care as a major concern. CAHPS data indicated that access to appointments remained a source of frustration for patients; this finding was corroborated by complaints data (specifically, complaints related to access had been increasing over the past year and now represented 51 percent of quality of care complaints) as well as a survey of satisfaction with behavioral health. In addition, an analysis of internal data found that appointment wait times had steadily increased over the course of the last several years.

In 1999, several HealthPartners’ medical groups participated in “Action Groups” supported by the Institute for Clinical Systems Improvement (ICSI) in collaboration with IHI. Through the action groups, the teams learned about the Advanced Access model and received support in implementing it at some of the clinics within their medical groups.

Initial assessments revealed little progress in improving patients’ experiences with appointment access, primarily because the clinics were struggling to overcome some of the

challenges of this model – including the backlog reduction and the skepticism of clinical and other staff. However, over time, the clinics have made measurable progress, including a statistically significant increase in the percentage of respondents that were very satisfied with their ability to get an appointment at their clinic at a convenient time (HealthPartners 2003).

Other examples of successful implementation of open access scheduling include the following (Murray and Tantau 2000):

- /// **Kaiser Permanente in Roseville, Northern California:** This clinic – which was the site at which the open access strategy originated – succeeded in lowering the wait time for routine appointments from 55 days to one day in less than a year. It also increased the changes that a patient would see his or her own physician from 47 percent to 80 percent.
- /// **The Mayo Clinic's Primary Care Pediatric/Adolescent Medicine Team:** Implementation of an open access model resulted in a reduction of the wait time for routine appointments from 45 days to within two days. The strategy also succeeded in lowering the number of daily visits on average.
- /// **The Alaska Native Medical Center:** At this medical center, open access led to a drop in the wait time for routine appointments in family medicine and pediatrics from 30 days to one day. They were also able to increase the percentage of patients seeing their own physician from 28 percent to 75 percent.
- /// **Fairview Red Wing Clinic, Red Wing, Minnesota:** In addition to reducing the wait time for routine appointments, this clinic succeeded in reducing the time required to cycle patients through the office from 75 minutes to 40 minutes. At the same time, it increased their time with physicians.

Advice from the UK

While the United Kingdom's health care system differs from ours in many ways, clinical practices in both nations struggle with many of the same issues with regards to improving access and patients' experiences with care. To assist practices in better meeting patients' needs, the UK's National Health Service (NHS) offers various resources through its Demand Management Group, including guidance related to reducing waits for routine and urgent appointments and clinical services.

To learn more about the NHS Modernisation Agency Demand Management Group, see its Web site at <http://www.demandmanagement.nhs.uk/home.php>.

For specific advice on these issues, see **The Little Wizard** and **The Big Wizard** at <http://www.demandmanagement.nhs.uk/wizards/index.php>

Key Resources

Murray M and Berwick DM. “Advanced Access: Reducing Waiting and Delays in Primary Care.” *JAMA*. Feb. 26, 2003. 289(8);1035-1040.

Murray M, Bodenheimer T, Rittenhouse D, and Grumbach K. “Improving Timely Access to Primary Care: Case Studies of the Advanced Access Model.” *JAMA*. Feb. 26, 2003. 289(8). 1042-1046.

Murray, M. and C. Tantau (2000). “Same-Day Appointments: Exploding the Access Paradigm.” *Fam Pract Manag* 7(8): 45-50. (See <http://www.aafp.org/fpm/20000900/45same.html>)

For information on how a health plan implemented this strategy, see:

National Committee for Quality Assurance (NCQA). “Primary Care Appointment Access: Reengineering the Appointment Process.” *Quality Profiles*. http://www.quality_profiles/case_studies/Service/1_34.asp

For information on collaboratives available to support the implementation of this strategy, contact:

The Institute for HealthCare
Improvement (IHI)
375 Longwood Avenue, 4th Floor
Boston, MA 02215
Phone: (617) 754-4800
www.ihl.org

The Institute for Clinical Systems
Improvement (ICSI)
8009 34th Avenue South
Suite 1200
Bloomington, MN 55425
Phone: (952) 814-7060
Fax: (952) 858-9675
www.icsi.org

For information on resources for VA Clinics, contact the Veteran’s Health Administration.

For information on resources for federally qualified community health centers and other primary care practices, contact:

- ⌘ The Bureau of Primary Care, which is part of the federal Department of Health and Human Services
- ⌘ The Primary Care Development Corporation of New York City

B.2 Streamlined Patient Flow

The Problem

In addition to the frustrations associated with waiting for routine appointments (as discussed in the previous profile of *Open Access Scheduling*), dissatisfaction with timely access to care also reflects unhappiness with the all-too-common waits for diagnostic tests, test results, treatments, hospital admission, and specialty services. While the waits seem unavoidable, they are often the result of redundancies, inefficiencies, rework, and other variations on waste in administrative and clinical processes.

The Intervention

There are many ways to address the problems that result in unnecessary and inappropriate delays in care, including the following:

- ⚡ **System changes, such as eliminating redundancies, understanding and adjusting demand, and doing things in parallel** (e.g., by using standardized x-ray and lab protocols that are ordered as a part of the registration process)
- ⚡ **Operational analyses of flows** (see example in box below) **and applications of queuing theory**

Example of Patient Flow Analysis

An analysis of patient flow involves tracking the experience of the patient during the visit, whether to a primary care practice, a specialist's office, or a site for clinical services (such as a lab or radiology facility). It can be as basic as a "flow mapping" – where you take detailed notes on your observations and impressions – or a more involved look at the time required to complete various parts of the visit. (Flow mapping is similar to a walkthrough or patient shadowing, which are discussed in greater detail in *Idea D.1: Listening Posts*.)

When conducting this kind of "cycle-time" measurement, be sure to separate out the time spent waiting in the waiting room and/or exam room and the time spent with the doctor. See the box below for an example.

This level of analysis can help a medical group identify problem areas and ways to reduce waits by eliminating unnecessary steps or being better prepared for visits. For example, a medical practice may decide to start previewing charts prior to visits or reviewing schedules each morning in order to better anticipate what may be needed (Backer 2002).

For a tool that enables patients to track cycle time in the office, see the following resource on IHI's QualityHealthCare Web site (www.QualityHealthCare.org): <http://www.qualityhealthcare.org/QHC/Topics/OfficePractices/Access/Tools/Patient+Cycle+Tool+IHI+Tool.htm>

Step	Time in minutes
Wait at check-in	2
Complete check-in	6
Wait in waiting room	14
Move to exam room	4
Wait for physician	10
Interaction with physician	19
Move to checkout	3
Check out	4
Total cycle time	65 minutes
Percent of time spent with a physician	29 percent

- /// **Collaborative improvement programs that pool the ideas from multiple clinics, hospitals, or health systems** — Organizations in both the U.K. and the U.S. have developed collaborative programs that bring groups of health care organizations together to make system changes aimed at achieving substantial improvements in waits and delays. IHI and the Veterans Health Administration have offered many collaborative learning programs to improve access to care, flow through the ambulatory care setting, and patients’ experiences of care.

For ideas for reducing waits associated with appointments for primary and specialty care, see:

- /// *Idea A.2: Rapid Referral Programs*
- /// *Idea B.1: Open Access Scheduling for Routine and Urgent Appointments*

Strategies that reduce delays in care have multiple benefits, particularly with regards to patient and clinician satisfaction. Other benefits include better outcomes, increased capacity to care for patients, and cost and efficiency savings (Simunovic, Gagliardi et al. 2001).

Because there are a number of ways to proceed, depending on the setting and the type of flow problem, it is difficult to describe concrete implementation steps in this guidebook. However, while some tactics require significant changes to well-established systems, others are fairly basic and easy to implement. For example:

- /// **Identifying and eliminating logjams.** For instance, an ophthalmology clinic found that patients who needed their pupils dilated were slowing down the flow because their appointment slot did not take this into consideration. The solution was to identify such patients and have them come 30 minutes prior to their consultation with the physician (NHS Modernisation Agency 2002).
- /// **Shifting tasks previously handled by specialists to other health professionals such as physician’s assistants and nurse practitioners.** These tasks may include performing histories and physical exams, basic prescribing, and ordering x-rays.
- /// **Developing and using standardized order sheets for common conditions or procedures.** By making it easier and faster for clinicians to communicate orders, this intervention enables them to spend more time with the patient. It also makes it more feasible for clinical staff to take on some of the clinician’s responsibilities.
- /// **Developing standardized patient information and instruction sheets,** possibly in conjunction with standardized order sheets and related protocols. These materials help staff streamline the patient education process while still ensuring that they meet the patient’s need for appropriate education and information.

Key Resources

A tool for measuring cycle time in the office (from www.QualityHealthCare.org): <http://www.qualityhealthcare.org/QHC/Topics/OfficePractices/Access/Tools/Patient+Cycle+Tool+IHI+Tool.htm>

Backer, Leigh Ann. Strategies for Better Patient Flow and Cycle Time. Family Practice Management. June 2002. Accessed at <http://www.aafp.org/fpm/20020600/45stra.html> on 5/6/2003.

Langley G, Nolan K, et al. *The Improvement Guide*. San Francisco, CA: Jossey Bass, 1996. In particular, see the appendices on change concepts and improving flow.

Woodcock, EW. *Mastering Patient Flow to Increase Efficiency and Earnings*. Englewood, CO: Medical Group Management Association, 2000.

B.3 Access to Email for Clinical Advice and Administrative Help

The Problem

One issue that affects patients, clinicians, and staff is the health system's reliance on conventional office visits and phone calls to relay information. In particular, patients are often frustrated in their attempts to get non-urgent advice and information from their clinician or from administrative staff without visiting the practice. First, calling hours are often inconvenient, especially for working patients. Second, when patients do call, they are typically put on hold, only to leave a message and hope they can avoid a game of "phone tag" with the clinician. Finally, unless the patient takes excellent notes, some of the information delivered over the phone may be lost or misunderstood.

The Intervention

One way to facilitate communication is to offer some or all patients the ability to exchange email with their clinicians' offices. Patients, clinicians, and office staff can use email for multiple purposes:

- /// To request and provide information or advice related to non-urgent concerns.
- /// To request administrative help (e.g., with forms) and schedule appointments.
- /// To request referrals.
- /// To communicate results of lab and diagnostic tests.
- /// To request and refill prescriptions.
- /// To transmit patient-monitored clinical measures, such as blood pressure, glucose levels, or temperature.
- /// To provide patient education and other materials, including links to appropriate Web sites.
- /// To send reminders.
- /// To clarify billing issues.

Recent surveys indicate that a significant number of patients – 90 percent of the 66 percent of all adults who have access to the Internet – are interested in communicating with their doctors online. Online patients say they would like to e-mail their physicians to do the following:

- /// Ask questions
- /// Schedule appointments
- /// Refill prescriptions
- /// Receive test results

More than half said that they might choose a doctor or health plan that offered online patient services over one that did not (Harris Interactive 2002).

What do Patients (or their Parents) Want?

- /// A survey of 325 parents and 37 physicians found that 74 percent of parents were interested in using email with their doctor or doctor's office, although not all wanted to communicate with the physician, i.e., they regarded email as a way to see lab results, schedule appointments, and get camp forms. In contrast, 79 percent of physicians did not want to communicate with patients via email, citing concerns about patient confidentiality and additional demands on their time (Kleiner, Akers et al. 2002).
- /// In a survey of patients in central Texas, respondents most often expressed interest in using email for prescription refills, non-urgent consultations, and lab results (Couchman, Forjuoh et al. 2001). Most patients (74 percent) would expect a response within 24 hours.

“When so many people want something—in this case the ability to communicate online with their physicians—the system (or the marketplace) will eventually provide it. It seems safe to predict that within a fairly short space of time many doctors will be communicating with their patients on the Internet. This will happen because some doctors and health plans will use this as a way to differentiate themselves from their competitors. Some doctors will embrace this as an opportunity to grow their practices. Some health plans will require, or incent, physicians to be accessible online. It is only a question of how quickly this will happen.”

(Harris Interactive 2002)

However, access to clinicians through email is currently limited. One study found that only six percent of respondents with Internet access used email to contact a clinician in the previous year (Baker, Wagner et al. 2003). And only 23 percent of those physicians who go online have reported that they use email to interact with their patients (Fulcrum Analytics and Deloitte Research 2002).

Email communication offers several benefits. It is convenient, fast, asynchronous (i.e., both people do not have to be available at the same time), unintrusive (i.e., it does not interrupt the recipient on either end), and easy to track and manage, unlike telephone messages. Because it facilitates communications between patients and their doctors, email has the potential to improve patient-centered care and increase self-management, while increasing timeliness and efficiency. Another possible benefit is improved adherence to treatment and medication, and a general increase in patient involvement in their own care (Mandl, Kohane et al. 1998). A recent study has also found cost savings associated with the use of online communications (RelayHealthCorporation 2003).

Another advantage of email is that it provides a written record of what transpired and what information was conveyed to the clinician and patient; copies of this documentation can be incorporated into the patient’s medical record (Kane and Sands 1998). However, the ability to integrate email into the medical record raises issues of informed consent and the adequacy of safeguards to protect privacy and confidentiality (Bauchner, Adams et al. 2002). (See more on this topic below.)

A number of organizations offer guidelines regarding the use of email in health care settings. Key sources include:

- ✎ Kane, B. and D. Z. Sands (1998). “Guidelines for the Clinical Use of Electronic Mail with Patients. The AMIA Internet Working Group, Task Force on Guidelines for the Use of Clinic-Patient Electronic Mail.” *Journal of the American Medical Informatics Association* 5(1): 104-11. These guidelines are available at the Web site of the Electronic Patient Centered Communication Resource Center: www.e-pcc.org.
- ✎ eRisk Working Group on Healthcare (2002). “Guidelines for Online Communications,” November 2002. (The *eRisk Working Group for Healthcare* is a consortium that includes the AMA, other leading national medical societies, and liability carriers.) These guidelines are available at www.medem.com/erisk.

The guidelines cover email content, informed consent, turnaround time, acknowledgements of receipt, documentation and record keeping, appropriateness of tone, and limitations (e.g., concerns about discussing sensitive subjects). Perhaps the biggest consideration in these guidelines is the security of personal health information and the liability risks associated with email communications, particularly in light of the new HIPAA regulations. (HIPAA refers to the Health Insurance Portability and Accountability Act of 1996.) HIPAA requires that health care organizations take steps to safeguard patient confidentiality by:

- /// ensuring that messages cannot be tampered with (by authenticating the contents),
- /// implementing the security standards for Protected Health Information (possibly through encryption), and
- /// maintaining records that can be audited.

The box at right offers a sample of the guideline recommendations. A list of useful resources, including sources of guidance on the HIPAA rules, is provided at the end of the description of this strategy.

Because of the security issues, there are basically two approaches you can consider if you decide to implement email communications. One option is to use existing email capabilities. This requires that the medical practice or clinic become familiar with the implications of HIPAA and implement various systems and measures to manage the flow of information (e.g., systems to forward the emails when a clinician is out of the office for a few days) and to minimize risk. However, while it is possible to comply with many aspects of the current guidelines for physician-patient electronic communications, you would not be able to offer a secure network through a standard email system.

A second, albeit more costly, option is to use the services of a secure messaging vendor; current examples include RelayHealth.com, MyDocOnline.com, HealthyEmail.org, and WellMed.com. These vendors offer off-the-shelf products that medical groups can use to send and receive information in a secure Internet-based environment. Typically, these products enable communications that are more structured and presumably more efficient than regular email would be, in that patients are submitting forms and templates rather than free-flow text.

Example of Communication Guidelines

Published guidelines combine common sense advice on how to make email communications effective and efficient as well specific recommendations for maintaining security and protecting personal information. For example:

- /// The medical practice should advise patients not to use email for urgent issues since the doctor may not see it right away.
- /// Clinicians, staff, and patients should avoid disclosing any highly sensitive and confidential information in an email because of the risk of interception or inadvertent transmission to the wrong party.
- /// Clinicians should respond to all emails from patients with whom they have established relationships, ideally by the next business day.
- /// Patients should include identifying information (e.g., a name and patient identification number) in the body of the message.
- /// Both clinicians and patients should send automatic replies to indicate that a message was received.
- /// Patients should be asked for their informed consent prior to using email communications.
- /// Clinicians and staff should develop and implement specific steps to decrease the risk of unauthorized access to patients' emails.

(Kane and Sands 1998; Sittig, King et al. 2001; eRisk Working Group on Healthcare 2002)

Because electronic communication – whether through standard email or secure networks – is fairly familiar to most patients and clinicians, this intervention does not face some of the technical and logistical obstacles typical of information system strategies. Some clinicians resist due to concerns about the privacy of electronic communications (particularly through standard email systems), while others worry about the potential volume of messages they could be asked to handle.

However, the lack of compensation to clinicians for their time poses the most substantial barrier. In a survey of doctors, over half of those who were not using email and who indicated a preference for “face-to-face” pointed to insurance reimbursement as the most important factor that would compel them to use email (Fulcrum Analytics and Deloitte Research 2002). (For an interesting perspective on these common concerns, see: *Using E-mail in Clinical Care: A Practical Approach Combining the Best of High-tech and High Touch*, by Daniel Z. Sands, MD, MPH, of CareGroup HealthCare System and Harvard Medical School, at <http://www.informatics-review.com/thoughts/pat-email.html>.)

A small number of health plans are paying doctors to do online consultations. For example, after a pilot program demonstrated improvements in patient satisfaction and health care savings of \$3.69 per member per month, several health plans — including Blue Shield of California, ConnectiCare, and Blue Cross Blue Shield of Massachusetts — agreed to reimburse physicians for online consults. (See Press Releases at www.RelayHealth.com.) However, it is not common for physicians to be reimbursed for the time they spend responding to emails (nor are they compensated for time on the phone).

Some of the secure messaging vendors are working with providers on this issue; in addition, some products incorporate ways to obtain payments directly from patients, especially for online consultations. In the Harris Interactive survey of patients with Internet access, over a third indicated a willingness to pay for online access to their clinicians (Harris Interactive 2002). Some health care organizations charge patients for access to email services; Portland-based GreenField Health, for instance, charges an annual fee of \$350 to each patient who wants to participate in the service (iHealthBeat 2003).

Example

Several health plans and medical groups have begun to use email to facilitate communications between patients and clinicians. At Washington-based Group Health Cooperative (GHC), for example, about 20,000 of 300,000 eligible patients have signed up for an online service called *MyGroupHealth* (www.ghc.org). Using the plan’s Internet portal, patients can communicate over a secure network with their personal health care teams, refill medications, and schedule appointments. The site also gives them access to searchable health information as well as discussion groups (see *Idea B.4: Internet Access for Health Information and Advice* and *Idea C.4: Support Groups and Self-Care*). In a survey of these online users, GHC found that 92 percent would recommend the service to others, and that 58% say they stay at GHC because of the online services (Eytan 2003).

Other Examples of Email Systems

Beth Israel Deaconess Medical Center and Caregroup HealthCare System in Boston, Massachusetts:
<https://patientsite.bidmc.harvard.edu/whatis.asp>

Palo Alto Medical Foundation:
www.PAMF.org Look for information on PAMFOnline. Patients are asked to pay a \$60 annual subscription fee for access to PAMFOnline Messaging, which allows them to communicate through a secure network to their doctors and advice nurses.

Geisinger Health System in Danville, PA: www.geisinger.org/mychart/index.shtml

University of Michigan Health System: www.talktomydoc.org

Key Resources

Web Sites Offering Useful Information and Links

Electronic Patient Centered Communication Resource Center: www.e-pcc.org This site offers a great deal of information on using email effectively in clinical practice.

Ferguson Report: www.fergusonreport.com

HealthyEmail (a nonprofit organization that offers educational materials, a secure communications tool, and related information on the use of secure email): www.healthyemail.org

iHealthBeat: www.ihealthbeat.com

Informatics Review (an electronic journal of the Association of Medical Directors of Information Systems): www.informatics-review.com

Massachusetts Health Data Consortium: Guidelines and related information on email use are available at <http://www.mahealthdata.org/>. See "Guidelines for the Use of Patient-Centered E-mail" by Daniel Z. Sands, M.D., M.P.H., Beth Israel Deaconess Medical Center and Harvard Medical School.

Medem (an Internet-based physician practice-patient communications network, sponsored by medical societies and their partners): www.medem.com

Articles

Mandl KD, Kohane IS, Brandt AM. Electronic Patient-Physician Communication: Problems and Promise. *Annals of Internal Medicine*, 15 September 1998. 129:495-500.

Moyer CA, Stert DT, et al. Bridging the Electronic Divide: Patient and Provider Perspectives on E-mail Communication in Primary Care. *The American Journal of Managed Care*, May 2002. 8(5). Also see: *First large doctor-patient e-mail study finds positive attitudes on both sides, but an increased communications burden to the clinic*, Press Release from the University of Michigan Health System, May 4, 2002. Available at <http://www.med.umich.edu/opm/newspage/2002/emailstudy.htm>.

Moyer CA, Stert DT, et al. We Got Mail: Electronic Communication between Physicians and Patients. *The American Journal of Managed Care*, December 1999 5(12).

Sands DZ. Electronic Patient-Centered Communication: Managing Risks, Managing Opportunities, Managing Care. *The American Journal of Managed Care*, December 1999 5(12).

For more information on HIPAA compliance for electronic communications, see:

HIPAA Advisory: <http://www.hipaadvisory.com/action/ecommm.htm>

HealthyEmail. *Email and the Clinical Practice*. February 2003. Available at www.healthyemail.org.

B.4 Internet Access for Health Information and Advice

The Problem

Many health care consumers seek information about specific complaints, conditions or diseases, drugs, nutrition, and fitness (Kassirer 2000). For these people, getting information quickly is a large component of “getting care quickly.”

In the past, patients and their families had to depend primarily on their physicians for this kind of information. In the last decade, of course, the Internet has evolved into an amazing resource for those seeking health-related information. Studies disagree on the number of Americans using the Internet for this purpose. For example:

- /// A survey conducted in early 2002 by the Pew Internet and American Life Project found that 62 percent of Internet users (about 73 million people) were looking for health-related information (Fox and Rainie 2002).
- /// Another survey found that the number was lower, with about 40 percent of people with Internet access using it for that purpose (Baker, Wagner et al. 2003).

For an explanation of the differences in these survey results, see: Wachter P. Discrepancies exist with online health info use. *iHealthBeat*. June 2, 2003. Available at www.ihealthbeat.com.

But there is little question that a large number of people are looking for information and advice on the Internet, and that the number is growing rapidly. Data from the 1999 American Internet User Survey suggest that health use is growing at a rate of 43 percent per year (Reents 1999). It also appears that the effect has been positive: In the Pew survey, 61 percent of “health seekers,” or 45 million Americans, reported that the Internet has improved the way they take care of their health either “a lot” or “some.”

However, the sheer volume often makes information on the Internet overwhelming, hard to navigate, and hard to validate. For example, the Robert Wood Johnson Foundation reported finding 19,000 health Web sites in a 2001 Yahoo! Search (Eng 2001). It is also hard for people to know whether a source of information is trustworthy. The Pew survey found that many seekers of health information on the Internet do not follow recommended guidelines for checking the reliability and timeliness of information: half reported that they check the date and source of information only occasionally, hardly ever, or never (Fox and Rainie 2002).

The Intervention

A number of health plans and medical groups have been exploring ways to channel consumers and patients to useful and reliable sources of information on the Internet. This strategy is meant to help address the demand for immediate information and to build on and reinforce the relationship of trust that health care organizations have with patients and members. While information on the Internet should not be a substitute for direct communication with personal care providers, it is a useful way to augment information sources for patients, especially when direct access to clinicians is not available.

One way to do this is to expand your own Web site to include health information and relevant tools as well as links to related information. Another simpler approach is to tell patients or members about external sites that could be helpful; this information could be provided during office visits, in printed materials, or in emails (which allow you to provide the address [URL] for the site). In a variation on this intervention, some clinicians are directing their patients to specific information on their diagnoses and treatment options; this approach is discussed in *Idea C.5: Delivery of Evidence-Based Information*.

The benefits of Internet access to health information and advice include improved quality of care, timeliness (i.e., 24-hour access), and efficiency. At least one study has found shorter duration of office visits, more phone consultations, and fewer and shorter hospitalizations due to an interactive, disease-specific networked computer system (Gustafson, Hawkins et al. 1999). In addition, consumers may benefit from quality of life gains, including improved psychosocial support, improved information-seeking ability, and reduced emotional distress (Gustafson, Hawkins et al. 2001).

For example, in a small pilot study where a family practice provided access to patient education Web sites during the office visit, researchers reported the following results after just one month:

- ✓ 90 percent were more satisfied with their visit because of the availability of the information.
- ✓ 94 percent of users found the information helpful.
- ✓ 77 percent felt the information would make them change their health behavior.
- ✓ 90 percent said they would use the clinic's Internet access again (Helwig, Lovelle et al. 1999).

While increasing numbers of health care organizations are embracing the use of the Internet to provide access to health information, some have expressed concerns about confidentiality, legal and liability issues, and reimbursement. Others are waiting for stronger evidence that these applications improve clinician efficiency, satisfaction, or quality of care (Eng 2001). Moreover, health care organizations may be reluctant to invest in this kind of functionality because they are not sure how to evaluate the information technology needed to implement it or how to integrate it into existing information systems.

A final obstacle for some organizations is that they are not certain that this strategy makes sense for the populations they serve. One common concern is that members or patients may not have access to the Internet; recent statistics indicate that 42 percent of Americans do not use the Internet, and 24 percent have no experience with it at all (Lenhart 2003). To help overcome the disparity in Internet access (often referred to as the "digital divide"), some health care organizations are taking explicit steps to educate members and patients on ways to get access to information on the Internet (e.g., through terminals available at clinics, practices, libraries, schools, and WebTV; or through family, caregivers, and intermediaries with direct access). A few are even providing access to Internet-based resources at their site (e.g., by installing terminals in clinic waiting rooms). A related concern is that providing better access only addresses part of the problem. The other part relates to Web literacy: the inability of some people with Internet access to navigate the Web efficiently or process all the information it offers.

Understanding the "Digital Divide"

To learn more about inequalities in access to the Internet, look at the Web site of the Digital Divide Network at <http://www.digitaldividenetwork.org/content/sections/index.cfm>.

To see recent statistics and a discussion of non-users, see: Lenhart, A. *The Ever-Shifting Internet Population: A New Look at Internet Access and the Digital Divide*. Pew Internet and American Life Project, April 16, 2003. Available at <http://www.pewinternet.org/reports/toc.asp?Report=88>.

To learn about differences in ability to use the Web effectively, see: Hargittai, E. *Second-Level Digital Divide: Differences in People's Online Skills*. First Monday. April 2002. 7(4). Available at http://firstmonday.org/issues/issue7_4/hargittai/index.html.

Some Examples

A Web search would yield many examples of health plans and medical groups directly providing health information and serving as portals to other sites. Two examples are provided below to illustrate the kinds of information and support available to plan members and other health consumers.

- ⚡ **Kaiser Permanente:** Members who sign in have access to in-depth health information and can refill prescriptions, make appointments, learn about health classes, and get personalized health advice from a clinician. They can also research health conditions, take personal health assessments (e.g., disease risks, healthy lifestyle) and join online health discussions (Kaiser Permanente 2003). See www.kaiserpermanente.org.
- ⚡ **Harvard Pilgrim Health Care:** At Harvard Pilgrim Online (see www.harvardpilgrim.org), consumers can research specific health topics, learn about disease management of specific conditions (e.g., diabetes, asthma), and find a specific doctor. Members can also email health questions and get a personalized response from a clinician (Harvard Pilgrim Health Care 2003). (See *Idea B.3: Access to Email for Clinical Advice and Administrative Help.*)

Other examples include Sharp HealthCare’s site at www.sharp.com and the Mayo Clinic’s site at www.mayoclinic.com. These sites are excellent examples of providing specific information about the health care organizations – practices, hours, policies about appointment waiting times, access to medical records – as well as health information and condition-specific resources.

Links You May Want to Offer

There are literally thousands of sites on the Web that may be helpful to your members and patients, including patient-support networks (such as bulletin boards and patient chat rooms) and disease-specific sites sponsored by medical associations, patient groups, government agencies (such as NIH), and others. You can do your members and patients a huge favor by sifting through some of these sites for them and recommending only those that offer timely, reliable, and objective information.

You may also want to provide links to the following sites, which enable users to conduct their own research:

- ⚡ <http://www.ncbi.nlm.nih.gov/entrez/query>: This site allows users to search MedLine, the bibliographic database of the National Library of Medicine (NLM). You can also get to this site through www.pubmed.gov.
- ⚡ www.pubmedcentral.nih.gov: PubMedCentral offers access to the NLM’s digital archive of life sciences journals.
- ⚡ www.medlineplus.gov: MedLinePlus offers direct access to health-related information. It is sponsored by NLM and the National Institutes of Health (NIH).
- ⚡ www.OncoLink.com: OncoLink provides free information on cancer to the public. It is sponsored by the Abramson Cancer Center of the University of Pennsylvania.
- ⚡ www.webMD.com: WebMD offers general information on health and wellness topics as well as a variety of message boards.

Example of an Online Information System for Patients: CHERS

In addition to the Web sites listed in the box above, there are a number of Web-based resources that offer information and support for people with various conditions. One example of an online service that providers can refer patients to is the **Comprehensive Health Enhancement Support System (CHERS)**. CHERS offers 11 online services to people with specific diseases (Breast Cancer and HIV have been developed so far). The services include disease information, decision-making tools, and support services (Gustafson, Hawkins et al. 2001).

The full list of services includes:

⚡ Information Services

- Questions and answers
- Instant library (articles from popular press and health/medical literature)
- Consumer guide (being a better consumer of health services)
- Referral directory (contacting local and national agencies)

⚡ Support Services

- Discussion groups (facilitated bulletin boards)
- Ask an expert (confidential responses to specific health questions)
- Personal stories of others with the same condition

⚡ Decision Services

- Self-assessment of emotional status
- Health charts for personal tracking
- Decision support
- Action plan (individual goals and resources to achieve them)

An evaluation of CHERS (specifically, the breast cancer resources) found that, compared to a control group, users had better access to relevant information and improved their social support. The benefits were greatest for women from underserved populations, i.e., those from the inner city and with lower socioeconomic status (Gustafson, Hawkins et al. 2001). An earlier study had found that the HIV application of CHERS resulted in patients needing 15 percent less time for office visits, having 47 percent more phone consultations, and experiencing fewer and shorter hospitalizations than patients in a control group (Gustafson, Hawkins et al. 1999).

For more information, visit <http://chess.chsra.wisc.edu/Chess/>.

Key Resources

Health Commons Institute: www.healthcommons.org. HCI’s Library and Bibliography offer extensive lists of articles and public and private resources related to using information technologies to improve medical decision making. HCI has also recently published “Seniors on the Internet: A Health Information Guide,” which is available on the Web site.

Internet Healthcare Coalition: www.ihealthcoalition.org

Pew Internet and American Life Project: www.pewinternet.org

Ferguson Report: www.fergusonreport.com

Consumer and Patient Health Information Section (CAPHIS) of the Medical Library Association: www.caphis.mlanet.org/consumer/.

Publications

Manhattan Research. *Credibility, Accuracy, and Readability: Consumer Expectations Regarding Online Health Information Resources*, May 2003. Available at www.manhattanresearch.com/expectations.htm.

Diaz JA, Griffith RA, et al. Patients’ Use of the Internet for Medical Information. *Journal of General Internal Medicine*, March 2002, 17(3): 180-185(6).

Sciamanna CN, Clark MA, Hoston TK, Diaz JA. “Unmet Needs of Primary Care Patients in Using the Internet for Health-related Activities,” *Journal of Medical Internet Research*, 2002, Dec 31; 4(3): e19. <http://www.jmir.org/2002/3/e19/index.htm> (Accessed August 11, 2003)

For some guidance on assessing health-related Web sites, see:

Gehle JL, Smith RM. The Informed Consumers: Evaluating Healthcare Web Sites. *WoMeN*. Quarterly newsletter of the Eastern Virginia Medical School Office for Women’s Affairs. Spring 2003. Available at <http://www.evms.edu/women/newsletter/evaluate.html>.

JAMA Patient Page. Health Information on the Internet. *JAMA*. 2001 May 23;285(20):2672.

Section 4-C

Improvement Strategies for “How Well Doctors Communicate”

This section presents seven ideas for improving the level of communication between clinicians and their patients. These strategies include interventions at the level of both providers and patients. But they all share a common purpose, which is to help health plans and medical groups do a better job of listening to members and patients, explaining things clearly, and supporting members and patients in their efforts to participate in and manage their care.

These ideas are as follows:

1. Training to Advance Physicians’ Communication Skills
2. Tools to Help Patients Communicate Their Needs
3. Shared Decision-Making
4. Support Groups and Self-Care
5. Delivery of Evidence-Based Information
6. Planned Visits
7. Group Visits

The last two ideas in this list are important elements of a more comprehensive strategy known as the Chronic Care Model, which is explained briefly on page 99.

These seven strategies are meant to address performance issues raised by the “How Well Doctors Communicate” composite, which is composed of the CAHPS questions in the box below.

By taking steps to improve communication between clinicians and patients, health care organizations help to create better relationships and better-informed patients who have a good understanding of both their conditions and appropriate treatment options. Empiric evidence suggests that these interventions are

CAHPS Questions in the “How Well Doctors Communicate” Composite

- /// In the last...months, how often did doctors or other health providers listen carefully to you?
- /// In the last...months, how often did doctors or other health providers explain things in a way you could understand?
- /// In the last...months, how often did doctors or other health providers show respect for what you had to say?
- /// In the last...months, how often did doctors or other health providers spend enough time with you?

associated with many desirable outcomes, including reduced postoperative pain and hospital stays, improved functional and physiologic outcomes, improved patient satisfaction, and better adherence to medical care (Maly, Bourque et al. 1999). Additionally, agreement between patient and physician about the nature of a health problem and the course of treatment appears to increase the likelihood of a successful health outcome (Stewart 1995).

C.1 Training to Advance Physicians' Communication Skills

The Problem

People rarely complain about the technical aspects of the health care they receive because – in the absence of an obvious error – patients are generally unable to judge technical competence. However, they and *only they* are well-equipped to judge the ability of clinicians to communicate with them effectively. Even though a clinician explains a diagnosis, test result, or treatment option to a patient, if the person walks away and does not understand the explanation, it has not been an effective communication.

Poor communication can have a serious impact on health outcomes. Patients may not provide the clinician with adequate information on their health or related concerns; they may not comply with the physician's orders – and in some cases, they may not even understand what they have been told. According to a study at the University of Kansas School of Medicine in Kansas City, patients' reports of their understanding of the post-discharge information and instructions they had received was significantly less than what their doctors perceived. For example, while the physicians thought that 89 percent of the patients understood the potential side effects of their medications, only 57 percent of patients said that they understood (Rogers 1999).

In addition to affecting the patient's experience with health care, poor patient-physician communication has important consequences for medical practices. One study found that, in a three-year period, 20 percent of Massachusetts state employees voluntarily left their primary care physician because of the poor quality of their relationship, which was a function of trust, the patients' sense that the physician knew them, the level of communication, and personal interaction (Safran, Montgomery et al. 2001). Poor communication is also a contributing factor in a majority of malpractice suits (Flaherty 2002).

While the curriculums of most medical schools now include some form of training in communications skills (Rogers 1999), this is a fairly recent phenomenon. Traditionally, medical education has paid little attention to the skills that promote effective interactions with patients. Most practicing physicians have not been taught to appreciate the patient's experience of illness; nor do they learn how to partner with patients and serve as a coach or guide. As a result, they typically do not know how to communicate with patients in a way that maximizes understanding, lets the patient know that his or her concerns have been heard, and ensures that the care plan meets the needs of the patient.

“With patient characteristics and structural features of care taken into account, those with the poorest-quality physician-patient relationships in 1996 were 3 times more likely to leave the physician's practice over the ensuing 3 years than those with the highest-quality relationships.”

(Safran, Montgomery et al. 2001)

The Intervention

To compensate for this deficiency in medical education, numerous health plans and medical groups are training practitioners in the communication skills they need – either through in-house programs or through communications programs offered by outside organizations (see

box on page 84). Most of these programs are optional, but a few organizations require the participation of all doctors. In some organizations, the program is mandatory only for those doctors who consistently receive low scores in this area.

The purpose of these programs is to improve providers’ effectiveness as both managers of care and educators of patients. It is also believed that trained physicians may allocate a greater percent of clinic-visit time to patient education, leading to increased patient knowledge, better compliance with treatment, and improved health outcomes.

The most effective and efficient way of offering training in physician-patient communication is in the form of seminars or workshops where you can cover many strategies for improved communication in a relatively short period of time. Workshops may also use case studies to illustrate the importance of communication and suggest approaches to improving the physician-patient relationship.

For clinicians, workshops may serve multiple purposes, including increasing their understanding of the physician’s roles; offering insight into the importance of connecting with patients; and increasing confidence in their interviewing skills. In addition to basic communication skills, the training can cover :

- ✍ history-taking skills,
- ✍ issues related to communicating across cultures,
- ✍ communicating with “problem” patients,
- ✍ interviewing techniques (including skills to help promote behavioral change), and
- ✍ empathic responses.

Timing Is Everything

Training in behavioral change concepts can help physicians identify patients who are likely to be receptive to their advice and guidance. The Transtheoretical Model, for example, lays out five unique “Stages of Change:”

1. Precontemplation is the stage in which there is no intention to change behavior in the foreseeable future. Many individuals in this stage are unaware or under-aware that a problem exists.

2. Contemplation is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action.

3. Preparation is a stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year.

4. Action is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.

5. Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. For addictive behaviors, this stage extends from six months to an indeterminate period past the initial action.

A full explanation of this model can be found at: <http://www.uri.edu/research/cprc/TTM/detailedoverview.htm> (Cancer Prevention Research Center 2003).

Some medical groups and health plans are teaching physicians about this model and encouraging them to identify where patients are in these stages and to focus their educational efforts on patients who are ready to change. If patients are precontemplative, physicians do not need to be spending much time convincing them to stop or start a new behavior. But if they are contemplative, then the time required to coach them about things they can do to adopt the desired behavior is well-spent.

Organizations that Offer Communication Training

Two organizations that offer courses and other resources to improve physician-patient communications are the Bayer Institute for HealthCare Communication and the American Academy on Physician and Patient.

The Bayer Institute for HealthCare Communication

The Bayer Institute offers a variety of workshops to help clinicians develop and hone their communication skills. It also offers books, videos, and practical guides on how to improve communication.

Three models of training options are currently available to health care organizations:

- ⌘ **Train-the-trainer:** The sponsoring organization may choose to have the Institute train one or more of its staff members to present the Institute's workshops back at the organization. Once they have completed the course, these trainers are considered a member of the Institute faculty and are eligible to receive training in all of the Institute's workshops.
- ⌘ **In-house consulting:** The sponsoring organization may hire a member of the Institute's faculty to conduct workshops on a consulting basis.
- ⌘ **Individual training:** The Institute also offers training for individual clinicians to improve their performance.

For more information about the Bayer Institute, visit the Web site at www.bayerinstitute.com or call (800) 800-5907.

The American Academy on Physician and Patient

The American Academy on Physician and Patient (AAPP) is an interdisciplinary group of medical educators and clinicians that share a common interest in patient-clinician communication and relationships, and psychosocial aspects of health care. The organization conducts and publishes research on the patient-physician relationship and offers courses for practitioners to improve and refine their communication style and techniques. AAPP also maintains an extensive bibliography of articles on doctor-patient communication and a library of educational videos.

For more information, visit the Web site at www.physicianpatient.org or call (703) 556-9222.

Some programs also address weaknesses in written communications, which can be a serious problem for clinicians who use email to communicate with some patients. Group Health Cooperative in Seattle, for example, offers a training curriculum on how to write emails to patients.

An Example

One of the best known examples of an in-house program to inculcate strong communication skills in clinicians is the **Thriving in a Busy Practice** program developed by Kaiser Permanente. This comprehensive communications curriculum strives to develop the ability of physicians to relate to patients effectively in both routine and difficult setting. In particular, it is intended to help physicians learn and practice techniques for dealing with difficult patient encounters. Over the past decade, the workshops have been expanded beyond the issues that typically confront primary care physicians to include guidance pertinent for different specialists (such as emergency physicians).

Evaluations of this program have found a positive impact on the clinicians. One study found that clinicians reported improved confidence in their ability to conduct effective medical

interviews and handle difficult situations. It also found that, after taking the course, fewer clinicians reported frustration with patient visits (specifically, the percent reporting frustration with 11 percent or more of patient visits fell from about half before the course to about one-third afterwards) (Stein and Kwan 1999). However, the impact on patient satisfaction is not yet clear: One study found that the program had no impact, but noted that other factors may have influenced that finding (Brown, Boles et al. 1999).

Key Resources

Bayer Institute for Health Care Communication
West Haven, Connecticut
<http://bayerinstitute.org/>
(800) 800-5907

The American Academy on Physician and Patient
McLean, Virginia
<http://www.physicianpatient.org/>
(703) 556-9222

Healthcare Communication Project, Inc.
<http://healthcarecommunication.org/>

Northwest Center for Physician-Patient Communication
Portland, Oregon
<http://www.tfme.org/nwppc.htm>
(503) 636-2234

Motivational Interviewing Web Site.
<http://motivationalinterview.org/clinical/whatismi.html>: Resources for clinicians, researchers, and trainers.

Publications

- Cultural Competence Compendium. (Section II: Resources Emphasizing Communication Skills). Chicago, IL; American Medical Association. 1999. Available at <http://www.ama-assn.org/ama/pub/category/2661.html>, or call (312) 464-5333.
- National Committee for Quality Assurance (NCQA). “Member Satisfaction: Reducing Complaints Through Improved Communication.” *Quality Profiles*. http://www.qualityprofiles.org/quality_profiles/case_studies/Service/2_21.asp
- Carrillo JE, Green AR, Betancourt JR. Cross-Cultural Primary Care: A Patient-Based Approach. *Annals of Internal Medicine*, 18 May 1999, 130(10):829-834.
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- Jackson C. It Pays to Listen: The Importance of Doctor-Patient Communication. *AMNews*. May 21, 2001.
- Nelson AM, Brown SW. *Improving Patient Satisfaction Now*. New York, NY: Aspen Publishers, Inc., April 1997.
- Nigg CR, Burbank P, Padula C, Dufresne R, Rossi JS, Velicer WF, Laforce RG, Prochaska JO. Stages of Change Across Ten Health Risk Behaviors for Older Adults. *The Gerontologist*, 1999. 39: 473-482.
- Prochaska JO, Norcross JC, et al. *Changing for Good*. New York, NY: William Morrow and Company, Inc., 1994.
- Prochaska JO. Helping Patients at Every Stage of Change. *Behavioral Approaches to Addiction Journal*, 1992. 1(1): 2-7.
- Ranier SB, Daughtridge R, Sloane PD. Physician-Patient Communication in the Primary Care Office: A Systematic Review. *J Am Board Fam Pract*. 2002. 15(1):25-38.

C.2 Tools to Help Patients Communicate Their Needs

The Problem

Communication is a two-way street. While the communication skills of physicians and other providers certainly play a large role in shaping the patient's experience, that patient's ability to express herself clearly, process and interpret the information she receives, and act upon it (e.g., by changing behavior) also contributes to the experience of care.

One issue is that many, if not most, patients are just beginning to become comfortable with relationships with clinicians that are based on a partnership model rather than the traditional paternalistic model. This shift is especially difficult for older patients and people who do not speak English or who come from cultures where this kind of a relationship with a doctor is unheard of.

But even those who embrace the idea of working collaboratively with physicians may lack important communication skills, which can inadvertently undermine their interactions with the health care system. Beginning in childhood, people are socialized to restrain themselves with doctors, answering only what they have been asked. While this attitude is changing, it is still a big step for people to accept that their agenda is as important as the doctor's, and an even bigger one for them to learn how to satisfy that agenda while still respecting the clinician's constraints.

The Intervention

Health plans and medical groups can help patients improve their ability to share information with providers by suggesting or even giving them one or more simple and inexpensive communication tools. Patients who can communicate effectively with their clinicians tend to be more satisfied with their care and less likely to sue in case of an error. Their clinicians are likely to be more satisfied with their caregiving experience as well.

There are several ways to implement this strategy, including the four tactics discussed below:

- /// Record Sharing
- /// Patient Question Lists (a.k.a. Doc Talk Cards)
- /// Feed Forward
- /// Coached Care

Record Sharing

Record sharing involves using the patient's medical record as a way to facilitate information sharing and generate discussion in the context of primary care. It typically consists of giving patients a copy of their physicians' progress notes (on paper or electronically) together with a glossary of terms. Access to this information enables patients to better understand their condition and treatment plan, to feel more in control of their health, and to identify and correct inaccurate information. Two factors may drive record sharing to become more commonplace: the HIPAA regulation that requires health care organizations to allow patients to review and amend their medical records, and the emergence of electronic medical records, which will make it easier to share legible (and therefore less confusing) information. Some health plans are already taking advantage of this capability: Geisinger Health Plan in Danville, PA, for example, offers members access to portions of their electronic medical record through the Internet. (See <http://www.geisinger.org/mychart/index.shtml>.)

Proponents believe that this intervention has the potential to increase compliance, improve patient safety, and enhance quality of care. Controlled studies indicate that the sharing of medical records has a consistently positive impact on doctor-patient communications, as well as modest benefits in other areas; with the exception of psychiatric patients, it appears to have little downside (Ross and Lin 2003). It has been found especially effective for patients with repeated visits, such as those with chronic conditions (Maly, Bourque et al. 1999) and pregnant women.

Patient Question Lists (a.k.a. Doc Talk Cards)

Another tactic is to encourage patients to write down questions they wish to ask their doctor and bring the list to their visit; these lists are sometimes referred to as “Doc Talk” cards. Typically, patients are asked to generate two to five questions about their medical problems or their reason for the visit that they would like their physician to answer during the office visit. The cards are often designed to prompt patients for questions by listing topic areas such as symptoms and medications. These questions can be attached to the patient’s chart for the physician’s review. This intervention is simple, requires few resources, and is effective at generating communication and increasing patient satisfaction with their care.

One tactic is to provide a form on the Web that patients can print out prior to their visit. PacifiCare’s Web site (www.pacificare.com), for example, offers members a form that suggests they write out answers to the following two questions and bring their response to the visit:

- ⚡ What do I want to **tell** my doctor today?
- ⚡ What do I want to **ask** my doctor today?

The plan also recommends that patients use the form during the visit to write down what they and the doctor agreed the patient would do after the visit.

Another approach is to maintain an ongoing record of health issues and concerns that the patient could share with his or her caregivers. Peace Health’s “Shared Care Plan” in Appendix D is one example of how this could be done.

Feed Forward

The Feed Forward concept is part of a model developed by Eugene Nelson and John Wasson that aims to use information to improve the ability of the microsystem to deliver effective care that addresses the patient’s needs. (See Section 1 of this guidebook for an overview of the microsystem concept.) The basic idea is that, prior to a visit, each patient completes a questionnaire that asks about perceptions of the care received to date, functional health status, clinical health status, and health risk status. The clinical team can then use that information to design and deliver a treatment plan that is appropriate for that individual. After the visit, the team collects similar information that can be used to redesign care for future patients (i.e., information for feedback). The model encompasses other steps as well, including a “prescription” that includes self-care assignments and tailored instructions.

For more information, see

- ⚡ Nelson EC, Batalden PB, et al. Microsystems in Health Care: Part 2. Creating a Rich Information Environment. *The Joint Commission Journal on Quality and Safety*. January 2003, 29(1).
- ⚡ Wasson JH, Stukel TA, Weiss JE, Hays RD, Jette AM, Nelson EC. A Randomized Trial of the Use of Patient Self-Assessment Data to Improve Community Practices.[Comment]. *Effective Clinical Practice*. 1999 Jan-Feb. 2(1):1-10.

Coached Care

“Coached Care” programs are designed to prepare patients to be more effective participants in their care by teaching them how to ask the right questions, how to interrupt, and how to get their needs met in the encounter. Coaching sessions may also address common misconceptions regarding a condition. Its goals include helping people become more assertive health care consumers, improving the quality of interpersonal care, and increasing patient involvement in treatment decisions.

The design of Coached Care programs varies from the inexpensive, where patients receive brochures prior to their visits that contain a list of common questions and other prompts, to more expensive programs involving individual coaching sessions between patients and designated clinic staff. For example, just prior to a doctor visit, a nurse may interview the patient, review the chart together, and generate a list of questions the patient has for the doctor. These more involved coaching programs require larger resources for staff training in Coached Care techniques in addition to financial coverage of staff time. While coaching sessions are usually performed in an office setting, they may also take place through email or over the phone.

Coached care programs have been shown to improve both physiologic and functional outcomes {Rost, 1991; Oliver, 2001; Greenfield, 1985; Greenfield, 1988}. A 1995 literature review of 21 studies found a definite correlation between effective

Books to Recommend to Patients

Clinicians may also support their patients by suggesting books that may help them communicate more effectively. Examples include:

Barbara M. Korsch, MD, and Caroline Harding. *The Intelligent Patient's Guide to the Doctor-Patient Relationship: Learning How to Talk So Your Doctor Will Listen*. New York, NY: Oxford University Press, 1998.

Nancy Keene. *Working With Your Doctor: Getting the Healthcare You Deserve*. Patient-Centered Guides, 1998. <http://www.patientcenters.com>

Nancy Oster, Lucy Thomas, Darol Joseff, and Susan Love. *Making Informed Medical Decisions: Where to Look and How to Use What You Find*. Patient-Centered Guides, 2000. <http://www.patientcenters.com>

Peter Clarke and Susan H. Evans. *Surviving Modern Medicine: How to Get the Best from Doctors, Family, and Friends*. Piscataway, NJ: Rutgers University Press, 1998.

Coached Care Enhances Breast Cancer Decision Making

To learn about the effects of a coached care program on breast cancer care, see:

Sepucha KR, Belkora JK, Aviv C, Mutchnik S, Esserman LJ. Improving the quality of decision making in breast cancer: consultation planning template and consultation recording template. *Oncology Nursing Forum*. Online. 2003 Jan-Feb. 30(1):99-106.

Sepucha KR, Belkora JK, Mutchnik S, Esserman LJ. Consultation planning to help breast cancer patients prepare for medical consultations: effect on communication and satisfaction for patients and physicians. *Journal of Clinical Oncology*. 2002 Jun. 20(11):2695-700.

Sepucha KR, Belkora JK, Tripathy D, Esserman LJ. Building bridges between physicians and patients: results of a pilot study examining new tools for collaborative decision making in breast cancer. *Journal of Clinical Oncology*. 2000 Mar. 18(6):1230-8.

physician-patient communication and improved patient health outcomes (Stewart 1995). In addition, anecdotal evidence suggests that Coached Care programs enhance physician-patient communication without requiring an increase in visit length (Kaplan 1995).

Some Examples

The PREPARE Program: The Bayer Institute for HealthCare Communication offers a communication improvement model for patients called the PREPARE Program. The *PREPARE to be Partners in Your Health Care: Six Steps to Help You Get More Out of Your Doctor’s Visit* program consists of a self-administered audio tape and a guidebook that can be used to prepare patients for medical visits. It is designed to be used in a brief time period such as while waiting to see the doctor. The program takes approximately 20 minutes to complete and is most effective when used immediately before the doctor’s visit and when the guidebook is taken into the visit as a reminder and place to write.

The Six Steps of Prepare	
Step One: Plan	Think about what you want to tell your doctor or learn from your doctor today. Once you have a list, number the most important things.
Step Two: Report	When you see the doctor, tell your doctor what you want to talk about during your visit today.
Step Three: Exchange Information	Make sure you tell the doctor and ask the doctor what is wrong with you.
Step Four: Participate	Discuss with your doctor the different ways of handling your health problems. Make sure you understand the good things and bad things about each choice.
Step Five: Agree	Be sure you and your doctor agree on a treatment plan you can live with.
Step Six: Repeat	Tell your doctor what you think you will need to do to take care the problem.

For more information on the PREPARE kits, contact the Bayer Institute for HealthCare Communication Web site at www.bayerinstitute.com. For more information about how to implement this program in a clinic, hospital, or managed care organization, please contact the program designer and manager, Maysel Kemp White, Ph.D. at 1-800-800-5907 or by email at maysel.white.b@bayer.com.

Consumer Tips on Patient Safety: Health plans and medical practices can help patients understand what they can do to get safer care by taking advantage of a communications program recently launched by several Federal agencies, including the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Office of Personnel Management, and the Department of Labor. Conducted in partnership with the American Hospital Association (AHA) and the American Medical Association (AMA), this campaign aims to distribute information about improving patient safety to health care providers and patients across the country.

Posters and fact sheets describe “5 Steps to Safer Health Care,” which are evidence-based, practical tips on the role that patients can play to help improve the safety of the care that they receive. These materials, which are available in English and Spanish, emphasize that good communication between health care providers and patients can often reduce a potential source of problems in today’s increasingly complex health care system. The tips are also included in CMS’s *Medicare & You* handbook, which is mailed to about 39 million Medicare households each year.

The AHA and AMA are encouraging hospital leaders and physicians to hang the posters in their waiting rooms and exam rooms to help encourage dialogue between patients and providers about health care safety. The groups also are distributing the posters through mailings and meetings.

Copies of “5 Steps to Safer Health Care” are available on the Web in English at <http://www.ahrq.gov/consumer/5steps.htm> or in Spanish at <http://www.ahrq.gov/consumer/cincorec.htm>.

Other Government Materials You Can Share

The Federal government offers several free documents that can be used to educate members and patients and prompt them to ask questions and take other steps to communicate more effectively. These materials can be ordered or downloaded from the Internet. Examples include the following:

- /// *Quick Tips – When Talking With Your Doctor*. Agency for Healthcare Research and Quality (AHRQ). AHRQ Publication No. 01-0040a. Available at www.ahrq.gov.
- /// *Talking With Your Doctor: A Guide For Older People*. National Institute on Aging, National Institutes of Health. NIH Publication No. 94-3452, September 2000. Available at www.niapublications.org.

Key Resources

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.

Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press, 2002.

The Bayer Institute for HealthCare Improvement: <http://www.bayerinstitute.com>

The American Academy on Physician and Patients: <http://www.physicianpatient.org>

HowsYourHealth: www.howsyourhealth.org – On this Web site, users can fill out a 10-minute survey on their health and health-related behavior. Based on the responses, the site generates a confidential form that summarizes that person’s health concerns. Users can share this form with their clinicians.

C.3 Shared Decision-Making

The Problem

Although they are far more informed than patients were even 20 or 30 years ago, some people express frustration and dissatisfaction with their care because they do not feel like they have adequate (if any) input into the decisions that clinicians are making about their health and their lives. One element of this problem is that patients often do not know enough about their treatment options to make informed decisions. In particular, they may not understand the evidence base underlying the decisions they are being offered.

Another contributing factor is that providers are not always supportive of patient involvement in the decision-making process. In some cases, clinicians are supportive of the concept but do not know how to make it happen.

Complicating the decision-making process is the fact that decisions related to preventive testing, diagnostic work-ups, and treatment options are often driven by physicians' preferences (which may be shaped by medical training, local norms, or personal experience) rather than scientific evidence. The resulting variations in care across the country are tremendous and well-documented. (For evidence of geographic variations, see the Dartmouth Atlas at www.DartmouthAtlas.org.) However, the only preference driving variations should be that of the patient. This is a core principle behind shared decision-making.

The Intervention

Shared decision-making is a model of patient-centered care that enables and encourages people to play a role in the management of their own health. It operates under the premise that, armed with good information, consumers can and will participate in the medical decision-making process by asking informed questions and expressing personal values and opinions about their conditions and treatment options. This intervention can be implemented by medical groups, but it is typically put in place and financed by health plans.

While some critics of shared decision-making maintain that patients are not able or willing to make their own health care decisions, there is considerable evidence that patients want more information and greater involvement in decision making in partnership with their doctors (Deber, Kraetschmer et al. 1996; Guadagnoli and Ward 1998). (Also see: Coulter A. *The Autonomous Patient: Ending Paternalism in Medical Care*. London: Nuffield Trust, 2002.)

Improved quality of medical consultations has been found to have a positive effect on the quality of treatment decisions, the quality of patient-physician communication, and the satisfaction of both patients and physicians. Specifically, research on the impact of this intervention has found:

- /// Consumer participation can increase patient satisfaction and lead to better health outcomes (Greenfield, Kaplan et al. 1985; Greenfield, Kaplan et al. 1988; Kaplan, Greenfield et al. 1989).
- /// Patients who are empowered to make decisions about their health that better reflect their personal preferences often experience more favorable health outcomes such as decreased anxiety, quicker recovery and increased compliance with treatment regimens (Guadagnoli and Ward 1998).
- /// Greater consumer involvement in decision making leads to lower demand for health care resources (Devine and Cook 1983).

Research also suggests that the use of interactive presentations can increase the complexity of discussions between physician and patient. In one study, both patients and physicians benefited from an increased level of understanding that allowed discussions to focus on the critical risk/benefit tradeoffs rather than simply describing treatment alternatives (Onel, Hamond et al. 1998).

The first step in shared decision-making is that patients become informed about their medical condition. Consumers have access to a variety of sources for such information, including physicians, friends and family, printed materials such as pamphlets and journal articles, community centers, and the Internet. But the innovation of shared decision-making is the use of interactive technology to inform patients. This method of informing patients may be applied to a variety of medical conditions as well as general preventive medicine.

Since this approach was first developed in the early 1980's, the use of video and computer technology has been increasingly seen as an effective means of helping patients make informed choices about their care. Interactive presentations can inform patients of treatment options, promote health, and teach self-management skills. Good interactive CD-ROMs and videos do not encourage any one treatment approach over the others; rather, they explain the issues fairly and clearly, highlighting the pros and cons of each option (Foundation for Informed Medical Decision Making 2003). Instructional applications may also be used to prepare patients for various procedures or explain what they need to know after surgery (Mechanic 1999).

The challenge to the technology is to keep pace with rapidly changing developments including new treatment alternatives and new information concerning treatment efficacy and complications (Onel, Hamond et al. 1998). Keeping them up-to-date is a major enterprise (Mechanic 1999).

Once the patient is informed, the second step is for the clinician to involve the patient in the decision-making process. However, while the right of patients to be informed decision makers is well accepted, it is not always well implemented (Institute of Medicine 2001). Shared decision-making requires a "modification of the relationship between patient and provider and recognition of the ability of the patients to participate in making choices that affect their lives." (Deber, Kraetschmer et al. 1996) Thus, one key to success lies in training physicians to help them understand how to facilitate the shared decision-making process and to ensure that they appreciate the importance of respecting patient's values, preferences, and expressed needs (Towle and Godolphin 1999). It is also helpful to use a team approach to shared decision-making so that the physician's time is used appropriately.

At the same time, patients must also take some responsibility for identifying and availing themselves of alternative sources of information, such as shared decision-making tools, the Internet, interactive CD-ROMs, and support groups or educational programs offered in the community.

Sources of Interactive Decision Aids

Foundation for Informed Medical Decision Making

One good resource for video-based decision aids is Health Dialog, which distributes decision-support tools created by the Foundation for Informed Medical Decision Making (FIMDM) in Boston, Massachusetts. FIMDM has developed portfolios of decision aids related to some of the most common and important medical conditions, including coronary artery disease, prostate cancer, breast cancer, back pain, osteoarthritis, benign uterine conditions, and benign prostatic hyperplasia.

According to FIMDM, their video tools present the latest clinical evidence about the risks and benefits of treatment options in ways patients can understand. In addition, they explain why there is sometimes a lack of evidence to support one option over another. Also included are interviews with patients who have undergone treatments and experienced good and bad outcomes, which helps to illustrate the variety of patients’ perspectives and concerns. These videos focus on helping patients engage in high-quality decision making with their doctors and supporting patients in carrying out their choices with confidence and competence (Foundation for Informed Medical Decision Making 2003).

A full list of the videos currently available through the Foundation for Informed Medical Decision Making and Health Dialog is available at <http://www.fimdm.org/programs.html>.

Blue Cross Blue Shield Technology Evaluation Center

Blue Cross Blue Shield has created a Technology Evaluation Center (TEC) on its Web site at www.bcbs.com/consumertec/whatis_tec.html. This Internet-based resource provides credible health care information to consumers to help them understand the scientific evidence on the effectiveness of treatments and tests. This service is designed to help consumers make more informed health care choices and communicate more effectively with their physicians in a decision-making partnership.

Health Dialog

Health Dialog (<http://www.healthdialog.com>) works with health plans and employers to improve the quality of care and reduce the costs of healthcare by enhancing the quality of patient-physician dialogs. Individuals participating in **Collaborative Care** better manage their chronic conditions, are more active participants in key treatment decisions, and are more confident about managing their health. The result is improved quality of care, improved satisfaction, reduced absenteeism, and reduced healthcare costs.

Health Dialog’s Collaborative Care Program includes ongoing processes for the following:

- ⌘ Regularly assessing how scarce care management resources should be deployed (using ever changing morbidity profiles and treatment pattern variation statistics)
- ⌘ Identifying individuals with “coachable high needs” (using proprietary predictive risk models that include both clinical factors and treatment pattern variation factors)
- ⌘ Reaching and engaging individuals with “coachable high needs” using an extensive library of direct mail materials and telephonic outreach protocols
- ⌘ Providing tailored nurse Health Coach telephonic support (which includes the dissemination of world-class evidence-based video, Web, and printed material produced by or reviewed by the Foundation for Informed Medical Decision Making)
- ⌘ Measuring and reporting outcomes

The Cochrane Collaborative

The Cochrane Collaborative is an international nonprofit organization that aims to support clinicians and consumers in making informed decisions based on the best available evidence. The Collaborative produces a Web site (www.cochraneconsumer.com) that is specifically designed to inform consumers by offering access to evidence reviews, which are summaries of research on health care therapies and advice. The site also helps consumers understand how to interpret the research that is conducted.

Key Resources

Gerteis M, Edgman-Levitan S, and Daley J. *Through the Patient's Eyes. Understanding and Promoting Patient-Centered Care*. San Francisco, CA: Jossey-Bass, 1993.

Finding a Balance. Blue Cross Blue Shield <http://www.bcbs.com/consumertec/pdf/Balance.pdf>

Laine C, Davidoff F. (1996). "Patient-centered medicine. A professional evolution." *JAMA* 275(2): 152-6.

Elwyn G, Edwards A, Gwyn R, Grol R Towards a feasible model for shared decision making: focus group study with general practice registrars. *BMJ* 1999; 319: 753-756.

Blue Cross Blue Shield Technology Evaluation Center: http://www.bcbs.com/consumertec/whatis_tec.html

Cochrane Collaborative: www.cochrane.org or www.cochraneconsumer.com

Resources for Decision-Making Tools on Video and CD-ROM

The Foundation for Informed Medical Decision Making: <http://www.fimdm.org/programs.html> (For a comprehensive bibliography on this topic, see: <http://www.fimdm.org/bibliography.php>.)

Health Dialog: <http://www.healthdialog.com>

CollaborativeCare.net: www.collaborativecare.net. CollaborativeCare.net is an online service of the Foundation for Informed Medical Decision Making and Health Dialog. Its purpose is to increase the availability of decision support to persons making choices about healthcare. Collaborative Care is based on the Foundation's concept of shared decision-making. It helps individuals become informed about their medical options, communicate effectively with their doctors, and achieve better overall health outcomes.

The Ottawa Health Research Institute: <http://www.ohri.ca/home.asp>. This site offers an inventory of international Patient Decision Aids including many of the shared decision-making programs in existence, evaluations of those programs, and the information about how to obtain them.

C.4 Support Groups and Self Care



The Problem

Patients often express dissatisfaction because they are not getting everything they need from the clinicians – but in many cases, what they need is not something that the clinicians can provide. While many physicians believe that they can (or should be able to) satisfy all of their patients’ needs, including the need for self-care, this presumption is not realistic or helpful for them or their patients – particularly for those with chronic conditions.

Many communities offer multiple resources that serve patients looking for support, advice, better self-care knowledge and skills, and comfort. Rather than setting expectations they cannot meet, clinicians need to accept that this is a role better filled by others and help their patients connect with the outside resources they need.

The Intervention

Health plans and medical groups can play two important roles to counter this problem. First, they can manage the expectations of members and patients by helping them regard their doctors as coaches rather than all-knowing sages. Second, they can offer access to the kinds of educational, behavioral, and emotional resources and support they need. Tactics for providing this support include self-care programs and support groups.

- 
Self-Care Programs: Self-care programs are usually highly structured educational forums where patients with a chronic condition may learn about a variety of topics, including symptom management, nutrition, community resources, medications, managing emotions, and communication skills (Lorig, Sobel et al. 1999; Lorig, Sobel et al. 2001). Self-care programs often teach skills that make people better able to manage their medical problems on their own, e.g., taking a blood pressure, giving injections, taking medications, and even performing diagnostic tests such as urine tests and blood glucose. Such programs are based on self-efficacy theory and emphasize problem solving, decision making, and confidence building (Lorig, Sobel et al. 2001).
- 
Support Groups: Support groups may take the form of face-to-face meetings or on-line chat groups operating under the principle that patients can learn to take responsibility for the day-to-day management of their disease. They help people who have chronic health problems by teaching them how to do a better job of self-care, providing emotional support, or offering other kinds of concrete support, like getting groceries or providing transportation to and from medical appointments. Other similar group interventions include survivor groups, 12-step programs, and psychoeducational groups for families of patients with chronic diseases (Mechanic 1999).

The use of support groups and self-care programs can increase patients’ knowledge about their disease and, in some cases, improve compliance with prescribed treatment. Additionally, these programs are beneficial to both patients and health facilities in that confident, knowledgeable patients practicing self-management have been shown to experience improved health status while utilizing fewer health care resources (Lorig, Sobel et al. 1999; Bodenheimer, Lorig et al. 2002). Additional anecdotal evidence suggests that such programs can have a positive influence on long-term health outcomes (Lorig, Mazonson et al. 1993).

Studies of support groups formed for chronic arthritis, heart disease, stroke, and lung disease have shown that such groups have beneficial effects on mental and physical health as well as social functioning. Specifically, support groups were found to (Lorig, Mazonson et al. 1993; Lorig, Sobel et al. 1999):

- /// increase communication with physicians,
- /// improve self-reported health,
- /// make enhancements in social/role activities, and
- /// reduce the need for hospitalizations.

These studies did not detect short-term improvement in other factors such as pain and psychological well-being, but there is evidence of significant improvements of these factors over the long-term.

Inexpensive self-care programs and support groups appear to be responsible for significant cost savings. Evaluations of some of these programs have shown fewer hospitalizations and days spent in the hospital as patients become more confident in caring for themselves. Additionally, one study found a total health savings of ten times the cost of the self-care program (Lorig, Mazonson et al. 1993; Lorig, Sobel et al. 1999).

Trained lay persons can effectively moderate support groups and educate patients in self-care techniques; this person need not have the same condition as the patients. Such instructors have been found to be acceptable to both patients and health professionals and are an inexpensive staffing option for these programs (Lorig, Sobel et al. 1999). Additionally, many guidebooks are available that can serve as a text for self-care programs or as a topical guide for support group meetings. The book “Living a Healthy Life with Chronic Conditions: Self-Management of Heart Disease, Arthritis, Diabetes, Asthma, Bronchitis, Emphysema & Others,” edited by Kate Lorig, has served these purposes for a variety of self-care programs.

Participants typically learn about self-care programs and support groups through referrals, fliers left in physicians’ offices, and/or program announcements posted at senior citizen centers and in patient or member newsletters. Additional cost savings could come from holding these meetings at the health care facility (if sufficient room is available) or at low-cost sites in the community, such as churches, senior centers, or public libraries.

Key Resources

Lorig K, Laurent D, Minor M. *Living a Healthy Life with Chronic Conditions: Self-Management of Heart Disease, Arthritis, Diabetes, Asthma, Bronchitis, Emphysema & Others*. Boulder, CO: Bull Publishing Company, 2000.

New Jersey Self-Help Clearinghouse

100 E. Hanover Ave., Suite 202
Cedar Knolls, New Jersey 07297

The New Jersey Self-Help Clearinghouse is a non-profit, statewide organization that helps people find and form self-help support groups. It is funded through the Division of Mental Health Services and sponsored by Saint Clare’s Health Systems in Denville, NJ.

C.5 Delivery of Evidence-Based Information

The Problem

Consumers and patients may consider their experience with care to be less than ideal because they did not receive sufficient information from the clinician during an office visit. They may want a better understanding of what a diagnosis means, what their treatment options are, what is going to happen to them, how they could better manage their health, what impact their behaviors have on their health, and/or what they can do to prevent or minimize the risk of other problems or further complications.

Unfortunately, a number of factors conspire to limit the ability of clinicians to educate their patients sufficiently:

- ✎ Clinicians often do not have enough time with any given patient to convey the information and answer questions.
- ✎ Comprehending complex medical information in the face of a stressful diagnosis or chronic condition is an iterative process for most people. One piece of information can easily generate a round of questions long after the office visit is over.
- ✎ Patients do not retain much of what doctors tell them. One study found that the average patient forgets half of what the doctor said within five minutes of leaving the room (Kitching 1990).
- ✎ Most people also want their families to understand what they have heard, but family members are usually not present at the visit. This problem alone can generate an enormous number of time-consuming follow-up phone calls.
- ✎ Clinicians are rarely compensated for spending time on this critical aspect of health care.
- ✎ Finally, while clinicians can take steps to be prepared for visits, they do not currently have at hand all the information that their various patients might need when they need it.

The Intervention

One way to facilitate patient education and behavioral change is to give patients access to pertinent and specific evidence-based information that they can use to educate themselves and make better decisions about their behaviors, their health, and their health care. Ideally, this strategy takes advantage of the electronic infrastructure emerging in many health care settings, but computer access is not necessary.

While there are several information products available to clinicians, one of the most prominent examples of this strategy is Information Therapy (Ix™). Launched in January 2002, Information Therapy aims to overcome many of the barriers that prevent health care consumers from feeling sufficiently informed and empowered to manage their health.

Information Therapy may be “prescribed” by a physician or by a health system or health plan (e.g., patients scheduled for a specific kind of appointment or procedure would automatically receive relevant information). It may also be “consumer-prescribed” in that consumers can independently research information about their health on their own. The information is designed to be accessible over the Web, but it may also be delivered in print.

Information Therapy is “the prescription of the right information to the right person at the right time in order to help patients make wise health decisions.”

(Center for Information Therapy 2002)

One drawback to instituting an Information Therapy program is the amount of technological infrastructure required. If this infrastructure is not already in place, this intervention may be costly for some sites or health plans.

The anticipated benefits of delivering pertinent, evidence-based information to patients include better management of chronic disease, prevention of medical mistakes, improved efficiencies within the delivery system, and overall improved quality and experience of care.

However, this strategy has not yet been extensively evaluated. A review of outpatient health behavior interventions utilizing computers as extensions of face-to-face encounters found that 13 out of 14 studies of targeted interventions reported improved patient outcomes (Revere and Dunbar 2001).

Key Resources

To learn more about Information Therapy or for information on how to begin an information therapy program:

- ✍ Contact the Center for Information Therapy at <http://www.informationtherapy.org>.
- ✍ See: Kemper D, Mettler M. *Information Therapy*. Boise, ID: Healthwise, 2001.

Also see: Doctors' Patient Education Network: www.drpen.com

Special Section: An Overview of the Chronic Care Model

Introduction

Over the past few decades, chronic conditions (such as heart disease, hypertension, diabetes, asthma, and depression) have been rapidly replacing acute and infectious diseases as the major cause of death, disease, and disability in the U.S. (Glasgow, Orleans et al. 2001). However, because the prevailing health care system is based on the diagnosis and treatment of acute illness, it is not well suited for the effective care of chronic illness.

Development of the Chronic Care Model

Clinicians and researchers have devoted significant resources to addressing this problem through chronic disease management, which has evolved into a comprehensive strategy for improving care for people with chronic illness. While disease management programs vary in design and implementation, almost all promote one or more of the six core elements of the Chronic Care Model (CCM) developed by Ed Wagner and colleagues as a framework for guiding specific quality improvement strategies (Wagner 2001).

- 1) **Health care organization and leadership:** An organizational environment that systematically supports and encourages chronic illness care through leadership and incentives results in more successful quality improvement activities (Wagner 2001).
- 2) **Linkage to community resources:** Community linkages can provide cost-effective access to services not available inside the organization, such as nutrition counseling, peer-support groups, and data for patient registries (Wagner 2001).
- 3) **Support of patient self-management:** Individual and group interventions that emphasize patient empowerment and self-management skills have been shown to be effective in the management of diabetes (Norris et al. 2001) as well as asthma and other chronic conditions.
- 4) **Coordinated delivery system design:** Innovations in delivery system design to coordinate actions of multiple caregivers of diabetics, for example, have led to significant improvements in glycemic control, patient satisfaction, and health care utilization (Sadur, Moline et al. 1999).
- 5) **Clinical decision support:** Incorporating evidence-based practice guidelines into registries, flow sheets, and patient assessment tools can be an effective method for changing provider behavior (Wagner 2001).
- 6) **Clinical information systems:** For example, with access to adequate database software, health care teams can use disease registries to contact patients to deliver proactive care, implement reminder systems, and generate treatment plans and messages to facilitate patient self-care (Glasgow, Orleans et al. 2001). (See box on disease registries on next page.)

The model is built on the premise that these six elements work together to create productive interactions between an informed, activated patient and a prepared, proactive practice team – which is what leads to improvements in outcomes.

What We Know About the Chronic Care Model

According to a recent literature review and survey of reputable programs, there is substantial evidence that chronic disease management strategies “achieve better disease control, higher patient satisfaction, and better adherence to guidelines by redesigning delivery systems to meet the needs of chronically ill patients.” (Wagner 2001) For example:

- /// **Acute Depression:** A simple but systematic program of feedback to doctors on treatment recommendations, supplemented with follow up and care management by telephone, was shown to significantly improve primary care treatment of patients with acute depression (Simon, VonKorff et al. 2000).

The Uses of Disease Registries

Registries are an important tool for monitoring and improving care for patients with chronic conditions. In essence, a registry is a list of patients with specific conditions. At a minimum, this list contains each patient's:

- /// Name
- /// Diagnosis
- /// Contact information
- /// Date of last visit

While a registry may be maintained on paper or in a computer system, a computer offers the ability to search, analyze, and manipulate the data. Ideally, a registry is linked with clinical data and guidelines so that providers can easily track their patients' progress and proactively address their needs for referrals, tests, consults, etc. (For some organizations, “tickler files” offer a low-tech alternative to registries.)

Registries can be very helpful in serving multiple purposes. Some examples of how you might want to use them include the following:

- /// To track clinical measures for patients
- /// To identify patients who need increased care management
- /// To identify patients that are missing important services or treatments across multiple chronic conditions
- /// To aid in preplanning of visits to ensure that patients' needs are met (e.g., by pre-scheduling blood work)
- /// To improve communication with patients with specific needs (e.g., diabetic patients with elevated levels of HbA1c)
- /// To identify patients needing education (based on pharmacy data)
- /// To provide feedback to providers on their performance
- /// To promote compliance with evidence-based guidelines
- /// To link to community-wide electronic medical records

For information on building a registry, see: White B. Building a Patient Registry From the Ground Up. *Family Practice Management*. November/December 1999. Available at <http://www.aafp.org/fpm/991100fm/improving.html>.

For tools to help identify and evaluate registry products, see the Improving Chronic Illness Care (ICIC) Web site: <http://www.improvingchroniccare.org/tools/criticaltools.html#registryevaluat>.

- ⚡ **Diabetes:** In a randomized trial to assess the impact of primary care group visits on the process and outcome of care for diabetic patients, the intervention group receiving self-management support through “mini-clinics” involving teams of providers exhibited better outcomes (including higher patient satisfaction and HbA1c levels) than the control group (Wagner, Grothaus et al. 2001).

Interventions Based on Model

Several of the specific interventions described in this Guide are drawn from the Chronic Care Model. In particular, the next two strategies – **Planned Visits** and **Group Visits** – are key elements of this model.

For that reason, it is difficult to assess them as stand-alone strategies. Also, while you can implement each of these strategies on their own, it is important to see them as components of a comprehensive and coordinated approach to care. Research studies suggest that the more aspects of the Chronic Care Model you use, the likelier you are to achieve better process and patient outcomes. (See: Renders, Valk et al. 2003.)

Key Resources

Improving Chronic Illness Care (ICIC) Program: www.improvingchroniccare.org

An important national resource for supporting implementation of the Chronic Care Model is the Improving Chronic Illness Care (ICIC) program. This program is funded by the Robert Wood Johnson Foundation and based at the MacColl Institute for Healthcare Innovation at Group Health Cooperative in Seattle.

Now in its third year, the ICIC program seeks to improve the care of the chronically ill through:

- ⚡ Improvement collaboratives,
- ⚡ A targeted research grants program, and
- ⚡ A dissemination program providing technical assistance and support to organizations interested in improving chronic illness care.

Working in collaboration with the Institute for Healthcare Improvement (IHI), ICIC has completed three national chronic condition collaboratives involving over 100 health care organizations participating in 12 to 13-month quality improvement programs. Each organization used the CCM to design and test system changes to improve care for a single condition such as diabetes.

To learn about an evaluation of the three Chronic Illness Care Collaboratives, see: <http://www.rand.org/health/ICICE/about.html>.

Partnership for Solutions: www.partnershipforsolutions.org

The Partnership is an initiative of Johns Hopkins University and The Robert Wood Johnson Foundation to improve the care and quality of life for people with chronic conditions. The Partnership focuses on identifying and communicating promising solutions based on existing research and its own original research on the problems faced by this population.

Also see: Kaplan A., Schoeni PQ (ed.). *Curing the System: Stories of Change in Chronic Illness Care*. Washington, DC: National Coalition on Health Care and Institute for Healthcare Improvement, May 2002. Available at <http://www.nchc.org/materials/studies/ACT3final.pdf>.

C.6 Planned Visits

The Problem

When patients with chronic illness report that their clinicians do not explain things well, they are often referring to inadequate support for, or training in, self-management of their illness. In many cases, clinical teams are not prepared to provide this kind of information during the patient's visit. Sometimes, the problem is that they are trying to fit it into an acute care visit, whether or not the reason for the visit is related to the chronic illness (Kern and Mainous 2001). A recent study by RAND found that patients received adequate counseling and teaching (i.e., interventions known to be a "best practice" for certain conditions) only 18 percent of the time (McGlynn, Asch et al. 2003).

"Too often, caring for chronic illness features an uninformed passive patient, interacting with an unprepared practice team, resulting in frustrating, inadequate encounters."

(Bodenheimer, Wagner et al. 2002)

The Intervention

One antidote to this problem is the planned visit, which is a component of the Chronic Care Model developed by Ed Wagner and colleagues at the MacColl Institute for Healthcare Innovation at Group Health Cooperative in Seattle. The purpose of the visit is to ensure that the clinical team reviews the care for each patient with a chronic illness and is proactive in providing the patient with all the elements of evidence-based care for his or her condition, including training in self-management.

These visits are pre-scheduled one-on-one visits, 20 to 40 minutes in length. During the visit, the clinical team and the patient review the patient's progress and work on clinical and self-management topics. A typical visit might cover some challenging aspect of self-management, such as medication adherence. Other health professionals, such as pharmacists, nurses, nutritionists, etc., may also play a role by identifying appropriate patients, preparing for the visit, or participating with the primary care physician in the visit. (For more details, see www.improvingchroniccare.org.)

Planned visits can be used for:

- /// specialty services,
- /// one-on-one visits with the primary care provider,
- /// reviews of medications and adherence, and
- /// psychosocial support (Wagner 2001).

Because this approach gives clinicians and patients the opportunity to review and strengthen the patient's self-management of his or her chronic illness (Bodenheimer, Wagner et al. 2002), planned visits can fill the gap left by acute care visits which, because of their focus on immediate symptoms, frequently allow little time for this kind of interaction.

Effective planned visits can lead to better clinical control of the illness (e.g., improvements in indicators such as blood pressure, cholesterol, HbA1c), reduce symptoms, improve overall health, and increase patients' sense of control over their health by providing them with ways to manage their own illness (Bodenheimer, Wagner et al. 2002). They may also lead to fewer acute care visits, reduced costs, and greater patient satisfaction.

Based on their experience with planned visits that focus on better medication management among patients 75 and older, the ICIC program recommends the following steps to conducting planned visits (Wagner 2001):

- /// Choose a patient population to focus on (e.g., diabetics, asthmatics, heart disease patients).
- /// Generate a list of patients at particular risk within the group. Patients at risk could include:
 - Those who are not adhering to their medications
 - Those with clinical evidence of poor disease control
 - Those who have not received important medications or other services indicated for their condition
- /// Call patients and explain the need for a visit.
- /// Schedule the visit and instruct the patient to bring all medications.
- /// Prepare for the visit (e.g., attach patient summaries to the front of the chart, prepare “Doc Talk” cards as described in *C.2 Tools to Help Patients Communicate Clearly* to identify the patient’s concerns)
- /// Reviews medications prior to the visit. (Physician consults with the pharmacy, if necessary.)
- /// At the visit:
 - Review the patient’s concerns and questions.
 - Review the patient’s clinical status and treatment.
 - Review medications; eliminate any unnecessary drugs and adjust remaining medications as necessary.
 - Identify facilitators to help patient with behavioral changes.
 - Discuss and resolve adherence issues with patient.
 - Collaboratively develop an action plan that the patient can and will follow.
 - Schedule a follow-up visit.

What We Know About the Value of Follow-Up Care

There is little literature on the effectiveness of planned visits because they are only one component of the Chronic Care Model described earlier.

However, more general studies of the effects of follow-up visits for chronic illness found that they improve the management of disease. For example, one study found that children and adolescents with regular follow-up visits for diabetes had better glycemic control, fewer episodes of diabetic ketoacidosis, and reduced likelihood of developing retinopathy compared to children and adolescents with irregular follow up (Jacobson, Hauser et al. 1997).

For More Information

These steps and a case example are reviewed in a video available from the ICIC Website at www.improvingchroniccare.org.

C.7 Group Visits

The Problem

Dissatisfaction with how providers communicate can arise when people need more attention, support, and information from the health system than they are getting. But in a typically brief office visit, clinicians do not have the time to cover everything the patient may need to know or to discuss all of their concerns (including problems with self-management.) As a result, the patient may feel that no one is listening or making the effort to explain things clearly. While the patient may be receiving various services, many of his or her needs are being missed.

This problem is particularly common for patients with chronic conditions, who are often struggling to understand how to control and live with their disease. A frequent consequence is that these patients become “high utilizers” of the health care system, particularly of emergency departments and urgent care centers – which tends to make them even less satisfied with their health care experience and more likely to have poor outcomes. These visits occur in part because the system of care does not provide patients with the tools, support, and information they need to manage their health problems adequately.

The Intervention

Group visits are an important component of the Chronic Care Model. In essence, they are a form of outpatient care that combines medical care, patient education, and patient empowerment in a group setting. In a group visit, patients with a common condition (such as diabetes) meet as a group under the guidance of one or more clinicians; participation in this group becomes part of their regular clinical treatment. This model dates back to at least 1990 when John Scott, M.D., of Kaiser Permanente Denver created the Cooperative Health Care Clinic (CHCC) for groups of 25 chronic care patients, 65 and older, who were high users of health care (Lippman 2000).

The benefits associated with group visits include reduced health care costs, greater patient and clinician satisfaction, patient empowerment, greater patient compliance, reduced repeat hospital admissions, and fewer emergency room and sub-specialist visits (Improving Chronic Illness Care 2002).

As a response to increased pressure for clinician productivity, this format can be an efficient way for patients to have face-to-face contact with their provider, get educational content, and learn from the experiences of fellow patients, without overly taxing the clinician’s time. These groups provide social and psychological support for the participants and help motivate them to follow their treatment plan and to take more responsibility for their own health (Improving Chronic Illness Care 2002). The clinician is spared the repetition of delivering the same educational message to multiple patients in traditional one-on-one encounters (Masley, Sokoloff et al. 2000), while patients get to share valuable information and insights with one another about self-management and quality of life issues.

There are several variations of the group visit concept. For example, in the model known as the drop-in group medical appointment (DIGMA), patients need not make prior appointments (Lippman 2000). Appendix D provides details on the various ways in which medical practices conduct group visits.

The implementation of group visits is not complex, but it does require advance planning and preparation. There are several good resources that describe how to establish and run group visits (see the box on Key Resources). A few considerations are worth mentioning:

- ⚡ First, choose an appropriate condition. Group visits are best suited for chronic illnesses, such as asthma, diabetes, arthritis, and obesity (Masley, Sokoloff et al. 2000).
- ⚡ Think carefully about which patients to invite. The goal is to identify patients who seem in need of better care, better advice on self-management, and more support. One way to do this is to focus on high-utilization patients, who can often be identified through pharmacy and billing records.
- ⚡ Keep the group a manageable size, perhaps 10 to 16 patients.
- ⚡ Pay attention to who is leading the group visit. Physician-led groups can be more effective at reducing no-shows than groups led by nurses or other mid-level clinicians. Also, it is important to avoid the impression that group visits are a way for physicians to avoid time with the patients.
- ⚡ Be sure to get the permission of participants to share information about them in the meeting. Also discuss the confidentiality of personal health information during the meeting itself.

Typical Format for a Group Visit

The meeting might last two or more hours and generally follows this format:

- ⚡ Introductions
- ⚡ Educational mini-lecture or discussion
- ⚡ A break during which clinicians conduct clinical work (e.g., review medication refill needs, check blood pressures and other clinical measures)
- ⚡ A discussion or question-and-answer period

They often end with clinicians meeting one-on-one with patients who were identified as needing extra follow-up.

Barriers to conducting group visits include privacy concerns, resistance from patients who do not want to participate in a group, and practical issues like adequate meeting space and available personnel. For many practices, the only space large enough to hold a group of people is the waiting room. Some medical groups get around this problem by conducting the group visits in the evenings; other organizations sometimes seek out space in the community that may be more accessible and familiar to their patients.

What We Know About the Impact of Group Visits

Evaluations of group visits have found promising results:

- ⚡ Randomized trials have shown that diabetic patients involved in group visits achieved better HbA1c levels than patients in a control group (Trento, Passera et al. 2001). Other studies of group education in diabetes have also found that HbA1c levels in the intervention groups were better than those of control groups; they also found evidence of improvements in patient self-care and satisfaction (Sadur, Moline et al. 1999), self-efficacy (Anderson, Funnell et al. 1995), and body weight and non-fasting triglyceride levels (Kronsbein, Jorgens et al. 1988).
- ⚡ In a study that compared a control group to a group of high users of HMO medical care who participated in group visits (all aged 65 and older with chronic conditions), the findings indicated that those in the intervention group were more satisfied with their care; had lower care costs; and had fewer ER visits, sub-specialist visits, and calls to physicians.

Nurse contact (phone and in person) was higher among the group visit patients. Also, participating physicians were more satisfied with caring for older patients than comparison physicians who relied on standard one-to-one interactions with their patients (Beck, Scott et al. 1997).

Key Resources

Improving Chronic Illness Care program: www.improvingchroniccare.org

Also see:

Houck S, Kilo C, Scott JC. (2003). Group Visits 101. *Family Practice Management*. May 2003. Accessible at <http://www.aafp.org/fpm/20030500/66grou.html>.

Lippman, H. (2000). Making Group Visits Work. *Hippocrates* 14(7).

Masley S, Sokoloff J, et al. (2000). Planning Group Visits for High-Risk Patients. *Family Practice Management*. 7(6): 33-7.

Section 4-D

Improvement Strategies for “Customer Service”

In the CAHPS 3.0 Health Plan Survey, some questions focus on customer service in the doctor’s office while others focus on service at the level of the health plan. In addition, the version of the survey submitted to NCQA (CAHPS 3.0H) includes questions about the health plan’s ability to handle complaints. These questions are listed in the table below:

For Medicare managed care enrollees, customer service is often a concern, with over a quarter of survey respondents reporting a problem of some kind getting help from customer service. (See Table 12 at top of next page.) For commercial enrollees, customer service and complaint resolution are the areas in which they rate their plans the lowest. Even in the best-performing plans, nearly 35 percent of members experienced a problem of some kind getting help from customer service (NCQA 2002).

This section reviews four tactics for improving customer service at the level of physicians, groups, and health plans:

- /// Listening Posts
- /// Patient and Family Advisory Councils
- /// Service Recovery Programs
- /// Standards for Customer Service

CAHPS Questions in the “Courteous and Helpful Office Staff” Composite

- /// In the last...months, how often did office staff at a doctor’s office or clinic treat you with courtesy and respect?
- /// In the last...months, how often were office staff at a doctor’s office or clinic as helpful as you thought they should be?

CAHPS Questions in the “Health Plan Customer Service” Composite

Questions from CAHPS 3.0 (Core Survey)

- /// In the last...months, how much of a problem, if any, was it to find or understand information in the written materials?
- /// In the last...months, how much of a problem, if any, was it to get the help you needed when you called your health plan’s customer service?

Additional Questions from CAHPS 3.0H

- /// Of those who called or wrote their health plan with a complaint or problem: How long did it take for your health plan to resolve your complaint?
- /// Of those whose complaint or problem was resolved: Was your complaint or problem settled to your satisfaction?

**Table 12. Problems with Customer Service:
The Experiences of Medicare Managed Care Enrollees
Percent of Respondents Who Reported No Problem Getting Help
When They Called Customer Service ***

Year	Mean	10th Percentile	25th Percentile	Median Percentile	75th Percentile	90th Percentile
2000	69.59	56.37	63.23	69.70	76.99	82.95
2001	71.70	57.18	64.29	72.45	80.34	85.16
2002	73.06	59.90	66.33	74.47	80.95	85.99

* Question: In the last 6 months, how much of a problem, if any, was it to get the help you needed when you called your Medicare health plan's customer service?

Source: Medicare Managed Care (MMC) CAHPS Survey

General Resources

Sage Consulting: www.sageteam.com

Leebov W, Vergare M, Scott G. *Patient Satisfaction: The Practice Enhancement Guide for Physicians*. Downers Grove, IL: Medical Economics Books, 1989. (Currently distributed by Practice Management Information Corporation at 800-MED-SHOP).

Leebov W, Scott G, Olson L. *Achieving Impressive Customer Service: Seven Strategies for Healthcare Managers*. Chicago, IL: American Hospital Publishing, 1998.

Leebov W, Afriat S, Presha J. *Service Savvy Healthcare: Achieving Impressive Service One Goal at a Time*. Chicago, IL: American Hospital Publishing, 1998.

Leebov W. *Customer Relations, Telephone Skills, Job Satisfaction Strategies, Stress: Controlling It Before It Controls You, Effective Complaint Management, Assertiveness for Healthcare Professionals, Effective Co-worker Relationships*. St. Louis, MO: Mosby Great Performance Co., 1995. A skill-building books for healthcare professionals.

Leebov W, Scott G. *Service Quality Improvement: The Customer Satisfaction Strategy for Health Care*. Chicago, IL: American Hospital Publishing, 1994.

Leebov W, Ersoz CJ. *The Health Care Manager's Guide to Continuous Quality Improvement*. Chicago, IL: American Hospital Publishing, Inc., 1991.

Leebov W, Scott G. *Health Care Managers in Transition: Shifting Roles and Changing Organizations*. Chicago, IL: Jossey-Bass Publishers, 1990.

Also see this report from the NCQA's Quality Profiles (www.qualityprofiles.org):

National Committee for Quality Assurance (NCQA). *Member Satisfaction: Systematically Analyzing Operations to Improve Overall Satisfaction*. http://www.qualityprofiles.org/quality_profiles/case_studies/Service/2_25.asp.


Group

D.1 Listening Posts

The Problem

Quality improvement activities that focus on the needs and experiences of customers – i.e., members and patients – can only succeed in an environment that emphasizes the concepts and responsibilities of “customer service.” One critical element of effective customer service is the capacity to elicit detailed, constructive feedback in a way that assures people that someone is really listening to them. When this is done well, members and patients are more likely to report a positive experience. At the very least, the organization should not be surprised by any negative reports.

However, this hands-on approach can be a major challenge for health care organizations that are not accustomed to communicating with their members or patients in this way. Many assume they understand how to fix the problem and do not probe beneath the surface of complaints and survey responses. For example, complaints that the office staff of a plan or a group are not helpful could stem from many sources:

- /// Not being given clear instructions about how to get to the practice
- /// Not being able to get an appointment when they needed it
- /// Being put on hold in the middle of a medical emergency
- /// Real rudeness and disrespect during a visit or on the phone

The solutions to these problems vary tremendously. Without digging deeper with patients or members to understand the true problem, a plan or group could waste a great deal of money on the wrong fixes.

The Intervention

The term “listening posts” refers to a variety of ways to learn about the experiences of patients and staff and involve them in the improvement process. Most already exist in some form in most health plans or clinical practices. The most difficult issue related to listening posts is building a system to routinely synthesize all of the feedback you receive from these different sources into a coherent picture of what they are telling you about the way you deliver care. Once this system is in place, you can perform root cause analyses to identify problems such as a particular staff member or medical group that accounts for many of your problems versus problems that are systemic to your delivery of care such as an antiquated manual appointment system.

“Listening posts” strategies include:

- /// Surveys
- /// Focus Groups
- /// Walkthroughs
- /// Complaint/Compliment Letters
- /// Patient and Family Advisory Councils (This last strategy is described separately in *Idea D.2* immediately following this discussion.)

Surveys

You can benefit from analyzing data from the annual CAHPS survey as well as from more frequent, small-scale use of CAHPS composites or individual questions to monitor a specific intervention. Analytical approaches are discussed in detail in Section 2 of this Guidebook.

Focus Groups

You can bring staff and/or patients together in a moderator-led discussion group to collect more precise information about a specific problem and new ideas for improvement strategies. A focus group allows for more in-depth exploration of the drivers of dissatisfaction and can provide excellent ideas for reengineering services. In addition, videotapes of focus groups can be very effective at changing the attitudes and beliefs of staff members because the stories that participants tell often bring to life the emotional impact of excellent service as well as service failures. To learn more about focus groups, see:

- /// Krueger RA, Casey MA. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, CA: Sage Publications, 2000.
- /// Bader GE, Rossi CA. *Focus Groups: A Step-By-Step Guide* (3rd Edition). San Diego, CA: The Bader Group, 2001.

Walkthroughs

A walkthrough may be the easiest way to give your staff the patient's perspective and the fastest way to identify system, flow, and attitude problems, many of which can be fixed almost overnight. Performing a walkthrough is an effective way of recreating for staff the emotional and physical experiences of being a patient or family member. Walkthroughs provide a different perspective and bring to light rules and procedures that may have outlived their usefulness. This method of observation was developed by David Gustafson, Ph.D. at the University of Wisconsin in Madison and adapted by Susan Edgman-Levitan to incorporate the staff perspective.

During a walkthrough, one staff member plays the role of the patient and another accompanies them as the family member. They go through a clinic, service, or procedure exactly as a patient and family does. They do everything patients and families are asked to do and they abide by the same rules. They do this openly, not as a mystery patient, and throughout the process ask staff members a series of questions to encourage reflection on the processes or systems of care and to identify improvement opportunities.

The staff conducting the walkthrough take notes to document what they see and how they feel during the process. They then share these notes with the leadership of the organization and quality improvement teams to help develop improvement plans. For many who do this, it is the first time they have ever entered their clinics, procedure rooms, or labs as the patient and family do. Clinicians are routinely surprised about how easy it is to hear staff comments about patients from public areas and waiting rooms. Walkthroughs usually turn up many problems with flow, signage, and wasteful procedures and policies that can be fixed almost immediately. (See recommendations for conducting a walkthrough in Appendix E.)

As an alternative to a walkthrough, you could use a similar technique called "patient shadowing," where a staff member asks permission to accompany a patient through the visit and take notes on the patient's experience. Since this approach does not require taking a slot away from a real patient, it can be useful in settings where visits are at a premium.

Complaint/Compliment Letters

By reviewing these letters systematically, you can often get a better picture of where you need to do more "background research" with staff and patient focus groups or a walkthrough versus when you need to get a manager involved to address a personnel problem. (For more on managing complaints, see *Idea D.3: Service Recovery Programs* as well as the discussion of customer service in Section 1.)

Key Resources

Roth MS, Amoroso WP. Linking Core Competencies to Customer Needs: Strategic Marketing of Health Care Services. *J Health Care Mark* 1993 Summer;13(2):49-54

Seybold PB. Get Inside the Lives of Your Customers. *Harv Bus Rev* 2001 May;79(5):80-9, 164

Gilmore JH, Pine BJ 2nd. The Four Faces of Mass Customization. *Harv Bus Rev* 1997 Jan-Feb;75(1):91-101

Seelos L, Adamson C. Redefining NHS Complaint Handling—The Real Challenge. *Int J Health Care Qual Assur* 1994;7(6):26-31

D.2 Patient and Family Advisory Councils

The Problem

For some patients and health plan members, the issue is not a concern about being heard. Rather, their dissatisfaction with their health care experience reflects frustration with a system that does not involve them in decisions that will affect the design and delivery of care. From their perspective, the system is superficially responsive: It acknowledges that a problem with service or care exists, but does not bother to investigate whether a proposed solution will really address the problem from the patients' or members' point of view.

Although patient satisfaction surveys provide extremely useful data, they are not the best source of information for innovative ideas about improving the delivery of care. Also, even plans and practices with high satisfaction scores often have many opportunities to improve services, which may not be revealed by survey data.

The Intervention

A Patient and Family Advisory Council is one of the most effective strategies for involving families and patients in the design of care (Webster and Johnson 2000). First designed and advanced by the Institute for Family-Centered Care, these councils are composed of patients and families who represent the constituencies served by the plan or medical group. It is important to involve both families and patients because they see different things and they each have an important perspective to consider.

The goal of the councils is to integrate the patients and families into the plan or practice evaluation and redesign processes in order to improve the experience of care and customer service. In addition to meeting regularly with senior leadership, they serve as “listening posts” for the staff and provide a structure and process for ongoing dialogue and creative problem-solving between the organization and its patients and families. (To learn more about this approach, see *Idea D.1 Listening Posts*.) The councils can play many roles but they do not function as boards, nor do they have fiduciary responsibility for the organization.

Council responsibilities may include input into or involvement in:

- /// program development, implementation, and evaluation;
- /// planning for major renovation or the design of a new building or services;
- /// staff selection and training;
- /// marketing plan or practice services;
- /// participation in staff orientation and in-service training programs; and
- /// design of new materials or tools that support the doctor-patient relationship. (For an example, see the Shared Care Plan in Appendix C.)

These councils help overcome a common problem that most organizations face when they begin to develop patient-and family-centered processes: They do not have the direct experience of illness or the health care system. Consequently, health care professionals often approach the design process from their own perspective, not the patients' or families'. Improvement committees with the best of intentions may disagree about who understands the needs of the family and patient best. But family members and patients rarely understand professional turf boundaries. Their suggestions are usually inexpensive, straightforward, and easy to implement because they are not bound by the usual rules and sensitivities.

In general, when starting a Patient and Family Advisory Council, it is best to start with members that are recommended by staff. Depending on the size of the organization, most councils have between 12 and 30 patient or family members and 3 or 4 members from the staff of the organization. The council members are usually asked to commit to one 2- to 3-hour meeting a month, usually over dinner, and participation on one committee. Most councils start off with one-year terms for all members to allow for graceful departures in case a member is not well suited for the council.

Look for people who can listen and respect different opinions. They should be supportive of the institution’s mission as well as constructive with their input. Staff members will frequently describe good council members as people who know how to provide “constructive critiques.” They also need to be comfortable speaking to groups and in front of professionals.

Key Resources

Webster, PD, Johnson, B. *Developing and Sustaining a Patient and Family Advisory Council*. Bethesda, MD: Institute for Family-Centered Care. 2000.

This manual is an excellent resource for organizations who are ready to establish these councils. The Institute’s Web site (www.familycenteredcare.org) is also a good source of information about related topics such as creating patient and family faculty programs.

Genovich-Richards J, Wyzkiewicz JV. Consumers: From Perceptions to Participation. *J Healthc Qual* 2002 Nov-Dec;24(6):39-41, 53.

Molnar C. Addressing Challenges, Creating Opportunities: Fostering Consumer Participation in Medicaid and Children’s Health Insurance Managed Care Programs. *J Ambul Care Manage* 2001 Jul;24(3):61-7.



D.3 Service Recovery Programs

The Problem

No matter how well you manage the customer service at your organization, problems are inevitable. Some may be serious, some may be minor, but they all play a role in shaping the member’s or patient’s perceptions of the organization and its responsiveness to their needs. Marketing researchers have found that the most satisfied customers are ones that have never experienced a serious problem or product defect. The next most satisfied customers are those who have experienced service difficulties, sometimes significant ones, that have been redressed by the organization. The least satisfied customers are those whose problems remain unsolved.

In surveys of Medicare managed care enrollees, only 56 percent reported that their complaint or problem was settled to their satisfaction (see Table 13 below). In contrast, nearly 80 percent of respondents enrolled in commercial plans said that their complaints were adequately addressed (NCQA 2002).

“When it comes to service recovery, there are three rules to keep in mind:
1. Do it right the first time.
2. Fix it properly if it ever fails.
3. Remember: There are no third chances.”

— Leonard Berry, Marketing Professor, Texas A & M University

Table 13. Satisfaction With the Resolution of Member Complaints: The Experiences of Medicare Managed Care Enrollees
Percent of Respondents Who Reported that Their Complaint or Problem Was Settled to Their Satisfaction *

<i>Year</i>	<i>Mean</i>	<i>10th Percentile</i>	<i>25th Percentile</i>	<i>Median Percentile</i>	<i>75th Percentile</i>	<i>90th Percentile</i>
2000	55.74	42.94	48.28	55.10	61.54	71.05
2001	56.53	44.00	47.83	56.48	64.62	71.74
2002	55.66	41.88	49.37	54.66	62.30	70.00

* Question: Was your complaint or problem settled to your satisfaction?

Source: Medicare Managed Care (MMC) CAHPS Survey

Most health plans and physician practices have some sense of the cost of replacing a lost member or patient. But many are not aware of how powerfully the “grapevine effect” can affect their reputations. Several marketing studies have confirmed that only 50 percent of unhappy customers will complain to the service organization, but 96 percent will tell at least nine or ten of their friends about their bad experience.

The “grapevine effect” can become an even more powerful force when your members and patients take advantage of the Internet to voice their complaints. Many Internet sites already allow patients to evaluate their experiences with a doctor, group, or plan on-line and some have the capacity to include written comments. Doctorquality.com, Healthgrades.com, and Healthcareprice.com are examples of proprietary sites that sell this kind of information to consumers. Several health plans, such as HealthPartners in Minnesota, also publish their

patient satisfaction data as part of their on-line provider directories. Consider the influence that consumer ratings have on restaurants (through Zagat’s surveys at www.zagat.com) and books and other products (through Web sites like www.Amazon.com).

In the same way that it can be helpful to remember that some problems or difficulties will always be with us, it is important to acknowledge that complaints are inevitable. Health care organizations are caring for people who are almost always anxious and afraid, so the stakes are higher. What differentiates member- or patient-focused organizations from others is whether and how they handle these incidents to ensure that unhappy members or patients feel like their concerns have been addressed and that the organization values them.

The Intervention

Service recovery is the process used to “recover” dissatisfied or lost members or patients by identifying and fixing the problem or making amends for the failure in customer or clinical service. Excellent service recovery programs are an effective tool for retaining members or patients and improving their level of satisfaction. Good service recovery programs can turn frustrated, disgruntled, or even furious patients or members into loyal ones.

Service recovery is about restoring trust and confidence in your ability as an organization to “get it right.” When members or patients repeatedly experience breakdowns in service, they begin to lose confidence in the care they receive. If you cannot get the small things right, how can they trust that you will do well with the complicated processes required to deliver high-quality care?

National experts in service recovery recommend a well-tested process for service recovery. This six-step process details how to handle a range of problems from the mildly irritated to the malpractice case in the making.

1. Apologize/acknowledge
2. Listen, empathize, and ask open questions
3. Fix the problem quickly and fairly
4. Offer atonement
5. Follow up
6. Remember your promises

Service recovery can range from listening to an upset patient to giving free parking to patients who have to wait more than a specified time for their doctor visit. It can also mean providing solutions or making amends for problems that the patient created. Making sure that someone gets to see a doctor when they show up on the wrong day is an example of the kind of customer service patients never forget. Service recovery programs ensure that patients never hear, “I can’t help you with this. It’s against our policy.”

According to Dr. Wendy Leebov, a national expert on service recovery in health care, service recovery is everybody’s job. When people complain, they usually address those complaints to front-line staff – but these staff do not necessarily have the skills or the resources to fix “system issues” that are often the source of the problem. Managers and the executive leaders have responsibility for redesigning dysfunctional work processes, systems, or even staff who may need to be moved to a different job.

Dr. Leebov has developed a very effective model for service recovery. Her model is described in detail in *Service Savvy Healthcare: One Goal at a Time* (see the list of resources at the end of this

description). Based on her experience with hundreds of health care organizations, the following five components must be in place to handle customer complaints and consistently impress your members and patients:

1. Effective systems for inviting/encouraging customers to complain.
2. Guidelines for staff and latitude to act and atone. (See box at right.)
3. Documentation and a feedback loop that channels problems revealed through service recovery into an improvement or problem elimination process.
4. Clear protocols for handling customer complaints effectively.
5. Staff skilled in service recovery – aware of protocols, and able to listen nondefensively, empathize, handle emotion, solve problems, and follow through to closure. (For an overview of what employees need to understand about complaints and service recovery, see Appendix F.)

Guidelines for Staff and Latitude to Act and Atone

Staff need to have the authority to make decisions about handling complaints autonomously so they can act quickly. Specifically, they need:

- ⚡ Clarity about the extent of their authority to act on complaints without getting approval from managers
- ⚡ Defined courses of actions for most frequent complaints
- ⚡ Minimal red tape
- ⚡ A clear system of resource people, clear authority lines, and backup systems for dealing with difficult situations or those with financial, legal or ethical implications

Good service recovery programs go beyond the “quick fix.” They include a process for tracking problems and complaints to help identify the source of the problem so the right improvement can be put into place. Some complaints arise from experiences with a specific person in the service process, which reflects a training problem, while others are the result of system problems that require a totally different process to resolve. The tactic of assigning complaint

letters received by the CEO to middle managers for resolution as if they all reflect a one-time event or an employee that needs disciplinary action is outdated, and will never result in permanent solutions to long-term problems. Many staff know immediately which situations or patients will end up in the CEO’s office. Organizations with good customer service and service recovery programs are proactive and let the CEO, clinic manager, or chief medical officer know about these situations right away so that the person can be contacted *before* they have the time to file a formal complaint.

“Eighty percent of customers’ problems are caused by bad systems, not by bad people.”

– John Goodman, Technical Assistance Research Programs (TARP), a market research firm based in Arlington, VA

What We Know About the Impact of Service Recovery Programs

Studies indicate that when customers’ problems have been satisfactorily handled and resolved, their loyalty and plans to use the services again were within a few percentage points of those who had not experienced a problem (Goodman 1988).

In other service industries, service recovery has proven to be cost-effective. Also, retention benefits the bottom line: Because of their word-of-mouth referrals and willingness to purchase ongoing services and premium products, customers retained over five years can be up to 377 more profitable than a “revolving door” customer who uses your services once (Reichheld and Sasser 1990).

Encourage Complaints

Health care organizations that are truly committed to improving the member’s or patient’s experience of care can make this commitment obvious to their staff and their members by encouraging complaints. Moreover, improvements in customer service depend on the organization’s ability to elicit and monitor customer complaints. In particular, service recovery cannot take place if the provider does not know that the member or patient is unhappy.

Many people would rather “switch than fight,” especially in a health care environment, where people fear that complaining could jeopardize the quality of the clinical care they receive. Also, minorities and people from under-served communities tend to avoid complaining, even though they may have significant problems with the delivery of care (Schneider, Zaslavsky et al. 2001; Zaslavsky, Zaborski et al. 2002).

If you make it harder for members or patients to complain, you will continue to miss important service failures that shape your reputation in the community and the quality of care. It is helpful to offer your members and patients multiple ways to give you feedback and help you improve your service. Several tactics for getting feedback are reviewed in *Idea D.1: Listening Posts*.

Also, there are many tools for cataloguing patient or member complaints that allow you to track the problems by CAHPS composite or other typologies that support linking the qualitative complaints to improvement activities (For one example, see the Feedback Monitor Pro at <http://www.radicallogic.com/>. This product integrates quick-response and productivity innovations to transform complaints, compliments and suggestions into valuable improvement opportunities. By simplifying documentation, enabling collaboration, and automating resource-intensive processes, Feedback Monitor Pro streamlines feedback management to ensure a high level of satisfaction and loyalty.)

The following table summarizes the most common steps in the process for managing complaints.

How to Use Complaint Management as an Effective Service Recovery Tool

Complaint Management Process Step	Actions to Take
1. Encourage use of complaints as a QI tool	Let your staff know that complaints are valued and essential for QI. Display complaints in public areas to reinforce the value you place on them. Make it easy for customers and staff to complain.
2. Establish a team of people to respond to complaints	The team should include people from the front lines as well as senior management. Use this team to develop planned protocols for service recovery for your most common service failures.
3. Resolve customer problems quickly and effectively	Commit the organization to resolving complaints quickly to avoid the waste of repeated contacts. Train and empower frontline employees to resolve problems and give them the authority to fix problems on the spot.
4. Develop a complaint database	Develop a computerized database that catalogs complaints by CAHPS composite or question to identify trends and generate regular reports to staff and management.
5. Commit to identifying failure points in the system	Using complaint data, identify failure points that are root causes of low satisfaction. Be proactive, not reactive; try to anticipate negative situations from occurring in the first place.
6. Track trends and use information to improve service processes	Stop handling problems one at a time as if they have never occurred before.

Adapted from Bendall-Lyon D. Powers TL. The Role of Complaint management in the service recovery process. *Joint Commission Journal on Quality Improvement*. 2001 May. 27(5):278-86.

Key Resources

- Zemke R, Bell C. *Knock Your Socks off Service Recovery*. New York, NY: American Management Association, 2000.
- Schweikhart SB, Strasser S, Kennedy MR. Service Recovery in Health Services Organizations. *Hosp Health Serv Adm* 1993 Spring;38(1):3-21
- Berry L. *Discovering the Soul of Service: The Nine Drivers of Sustainable Business Success*. New York, NY: Free Press, 1999.



D.4 Standards for Customer Service

The Problem

Achieving high levels of member satisfaction requires two ingredients:

- ⚡ A deep knowledge of what constitutes high quality service from the perspective of your members and patients
- ⚡ Service standards that clearly tell your staff what is expected of them in their interactions with members and patients

However, while most of the accrediting organizations require such standards in their regulations, most health care organizations do not have a well-defined process for developing effective standards. One barrier is that setting standards takes time. However, Dr. Wendy Leebov and other national experts in this area argue that the absence of standards necessitates spending time on far more unpleasant activities, such as responding to complaints and managing unsatisfactory staff behavior.

Another problem with developing standards is that some of the behaviors are hard to describe. It can be challenging to describe what good and excellent service feel like. Setting standards is also fundamentally about being accountable to high standards of service on a daily basis. That is a challenge in health care systems that are often deeply grounded in a culture of professional autonomy.

The Intervention

Customer service standards are already embedded in many of the CAHPS survey questions. These questions were selected because they measure processes of care that patients and members use to define a “quality experience.” However, that does not mean it will be easy to translate the questions into standards that your staff can measure and evaluate.

In some respects, standards are similar to “service guarantees” – a concept that frightens many health care employees because they do not trust that the systems they need to meet “guarantees” are in place. Organizations that maintain their focus on service often find that the standards evolve over time. As the organization gets better and better at meeting the needs of its patients, the staff are willing to raise the standards they commit to and trust that they will be able to deliver.

Examples of standards that some plans or groups have implemented include the following:

- ⚡ 90 percent of patients who call for an appointment will receive one for the same day.
- ⚡ Patients will wait 10 minutes or less in the reception area before being placed in an exam room.
- ⚡ All telephone calls will be answered within three rings.
- ⚡ All test results will be communicated in writing to the patient after an ambulatory care visit.

Leebov et al. describe a step-by step process to help set standards that everyone can abide by (Leebov, Scott et al. 1998). The steps are as follows:

1. Work with staff and managers to resolve any mixed feelings or uncertainty about setting high standards and holding staff accountable.
2. Help your team to commit to aiming high and setting ambitious goals.
3. Engage your customers and staff in identifying basic service behaviors that reflect impressive customer service.

4. Use these guidelines to identify job-specific behaviors.
5. Crystallize these behaviors into scripts and protocols (see box on “Talking Points”).
6. Design and institute measurable service standards that you expect your people to meet regularly. (See example below.)
7. Set service targets – stretch goals – that will have a significant impact on customer satisfaction and that can become standards.
8. Monitor performance.
9. Hold yourself and your team accountable.

Although this process may require a big change in an organization’s culture, it is very valuable. Without these kinds of standards in place, most organizations cannot sustain a meaningful focus on patient-centered improvements.

Example of Service Standards for a Pharmacy Department: Kaiser Permanente, Washington DC

Our department will abide by the following standards to guarantee caring and quality service is provided to our members and in-house customers.

Service Standards to our Members

- ⚡ We will greet our members in a courteous and professional manner.
- ⚡ We will listen effectively to our members’ requests and promptly take the necessary actions to assist them.
- ⚡ We will keep our members informed of unexpected delays in service.
- ⚡ We will not engage in personal conversations while providing service to our members.
- ⚡ We will call our members by name and will verify identity by means of address and/or ID card.
- ⚡ We will inform our members of specific departmental procedures (e.g., refill line, last refill, mail order) to help them maximize pharmacy services.
- ⚡ We will finish our encounters with our members in a courteous and professional way.
- ⚡ We will respect our members privacy and will not discuss member-related information in public.

Service Standards to our In-House Customers

- ⚡ We will interact with our co-workers and company staff in a courteous and professional way.
- ⚡ We will not discuss staff, organizational policies, problems, or medical care in public areas.
- ⚡ We will be considerate, and we will cooperate and assist co-workers, staff, and other departments to guarantee quality service.
- ⚡ Telephone etiquette:
 - We will answer the phone within four rings.
 - We will provide our center location, our name, and our department and politely ask: “How may I help you?”
 - We will listen to the caller’s request and assist accordingly.
 - We will direct the call to the person, department, or service needed to assist the caller.
 - We will obtain the caller’s permission before placing the caller on hold.
 - We will end the call in a courteous and professional way.
 - We will omit personal phone calls while on duty.

“Talking Points”

Talking points or scripts ensure that everyone in the organization is delivering a positive message in a consistent way to your members and patients. These messages make sure that you are meeting your service standards and build these behaviors into predictable, daily routines. Work with your staff to develop the talking points and to help them understand that scripts are not intended to turn your staff into robots. Rather, they are reminders of the minimum that staff can do to create a positive experience for members and patients.

Once people become familiar with the design and intent of talking points, they often realize how helpful they are when dealing with frightened or upset patients. Simply put, scripting:

- ⚡ Conveys the message of your culture, “this is how we do business around here.”
- ⚡ Puts words to your behaviors.
- ⚡ Sets clear expectations for what is supposed to happen in encounters.

Here are some examples of how scripts can help to change communications:

<i>Instead of...</i>	<i>Say...</i>
“No, I don’t have the time.”	“Yes! I can help you in five minutes.”
“We’re short staffed.”	“We may be busy, but we’re never too busy to help you!”
“I don’t know.”	“I think I can help you find the answer.”
“It’s the doctor’s fault and I can’t believe that happened.”	“I’m sorry that happened. What can I do to help?”

(Adapted from *Scripting*, Baptist Healthcare Leadership Institute, Pensacola FL, 2003)

Other examples of the most common and powerful talking points are:

- ⚡ “How can I help you? I have the time.”
- ⚡ “How can I make this better for you?”
- ⚡ “I’d like you to meet, XXXX, your doctor, nurse, etc. She will take excellent care of you.”

When staff are resistant to using scripting, remind them that their personalities will always come through yet they will be delivering a consistent message that reflects your organization’s high standards. Reward employees who use scripting effectively and make it easy for people to remember the most common and important message by putting them on the back of name badges or other convenient places.

For further guidance, see: *Scripting*. Pensacola, FL: Baptist Healthcare Leadership Institute, 2003.

Case Example:

Customer Service Interventions at Harvard Pilgrim Health Care

Based on its analyses of CAHPS data as well as other data, Harvard Pilgrim decided to design a set of interventions aimed at improving telephone access as measured by Average Speed to Answer (ASA) and Call Abandonment Rates. Some of the interventions also improved the consistency, clarity, and timeliness of responses to member inquiries and the availability of written member materials.

The plan implemented two types of interventions:

Interventions aimed at increasing self-service options for members

The purpose of these interventions was to improve access and reduce call volume to Customer Service Representatives.

- /// Installed an Interactive Voice Response (IVR) system to enable members to get quick answers to the most frequently asked questions and to place the most common requests (e.g., new identification (ID) card, change of address, change of primary care provider (PCP)) without the intervention of a service rep. This system operates all day, everyday. Through focus groups, members helped to design the IVR, which has been evaluated and fine-tuned over time.
- /// Installed an after hours voice-mailbox so that members could leave an inquiry in the evening or over a weekend and receive a call back from a Customer Service Representative in the morning of the following business day.
- /// Developed and implemented Web-based FAQ (frequently asked questions) materials, downloadable member materials (e.g., benefit plan descriptions), online service requests (new ID cards, address and PCP changes), and email inquiries. The materials and requests are available around the clock, with service and inquiry responses within 24 hours.
- /// Currently developing a much broader range of self-service options (e.g., change own address or PCP, see claims status, view prescription history, etc.).
- /// Implemented financial incentive program for Customer Service Representatives to promote the self-service options to members

Interventions aimed at *increasing efficiency and responsiveness* of Customer Service representatives

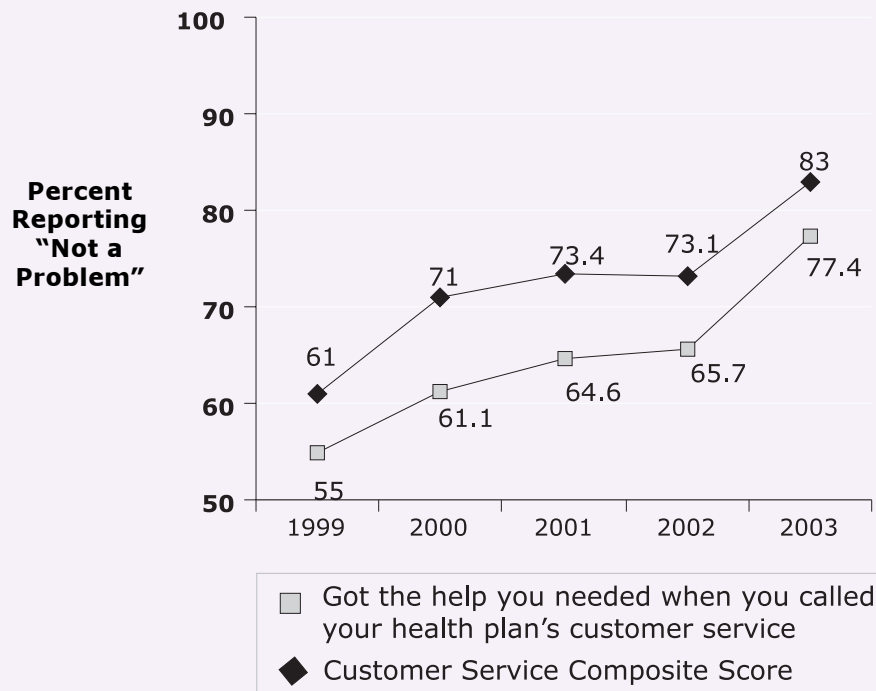
- /// Simplified and standardized product offerings and benefit policies.
- /// Installed an intranet-based reference system for service representatives to assure quick and consistent responses to member inquiries: fine-tuned it over time to provide quick links to frequently viewed pages.
- /// Increased manager and staff training and improved and streamlined staff resource materials.
- /// Improved internal communication and workflow between Customer Service and Claims departments to resolve members' inquiries about claims.
- /// Expanded hours of operation to 7:30 PM on Mondays and Wednesdays (peak volume days).
- /// Implemented a series of performance incentive programs for Customer Service Representatives that were tied to the goals of reducing ASA and Call Abandonment Rates.

Case Example (continued)**Results of Interventions at Harvard Pilgrim****Performance on Internal Metrics**

Performance Measure	Current Goal	Q4 2000	Q4 2001	Q4 2002
Average Speed to Answer	30 seconds or less	67 sec.	47 sec.	28 sec.
Call Abandonment Rate	3% or less	5.6%	2.8%	1.5%

Performance on CAHPS Measures

Member Services Telephone Access
Improvement 1999-2003



CAHPS Item: In the last 12 months, how much of a problem was it to get the help you needed when you called your health plan's customer service?

Section 4-E

Improvement Strategies for “Claims Processing”

The HEDIS version of CAHPS (known as CAHPS 3.0H) includes a few items related to claims processing that build on the question about paperwork in the core survey. These questions are listed in the table at right.

These few items can have a major impact on a health plan’s CAHPS scores. In fact, many plans have found that claims processing is the single most important driver of the overall health plan rating.*

The Problem

Several related factors contribute to members’ experiences with claims and paperwork:

- ⚡ When bills are not paid accurately or in a timely fashion, providers may pass their dissatisfaction along to their patients, and sometimes pass their bills along as well. In some cases, providers resubmit the claim, which can clog the system and add to further delays.
- ⚡ Members who receive a bill for a covered service often see that as a failure on the part of the health plan, even when the problem may have originated with the provider.
- ⚡ Finally, when members call their provider about a bill that they believe was received in error, they are frequently referred to their health plan. This reinforces the perception that the health plan is at fault, whether or not that is true.

In addition, members sometimes experience problems with claims they have submitted directly, as well as those submitted by providers on their behalf.

To address the scenario described above, health plans must start by identifying the most likely causes of two common problems: inaccurate claims payments and delays in claims payments.

Inaccurate payments can occur when providers submit incorrect or incomplete information, which may result in inappropriate denials of payment. They may also be the result of complex benefit designs and/or multiple fee schedules that complicate the the plan’s claims processing algorithms and produce errors. Finally, members may perceive that a claim was handled incorrectly because they misunderstood their benefits and/or coverage limitations. (One way to probe this possibility is to check the results for the CAHPS item on understanding information in the health plan’s written materials.)

CAHPS 3.0H Questions on Claims Processing

- ⚡ In the last...months, how often did your health plan handle your claims in a reasonable time?
- ⚡ In the last...months, how often did your health plan handle your claims correctly?
- ⚡ In the last...months, before you went for care, how often did your health plan make it clear how much you would have to pay?

CAHPS Question on Paperwork (from the “Customer Service” Composite)

- ⚡ In the last...months, how much of a problem, if any, did you have with paperwork for your health plan?

* Personal communication with Kathryn L. Coltin, MPH, Director of External Quality and Data Initiatives, Harvard Pilgrim Health Care, October 2003; based on unpublished reports analyzing the CAHPS performance of health plan members of the New England HEDIS Coalition.

Delays in claim payments may be due to:

- ⚡ Pended claims due to incomplete information submitted by providers
- ⚡ Health plan protocols and/or dollar thresholds for pending claims for manual review
- ⚡ Backlogs due to pended claims and resubmissions of claims already in the system
- ⚡ Submission and processing lags associated with paper claims and manual processing
- ⚡ Cash flow policies at health plans that can delay payment even when processing has been completed

The Intervention

While different interventions need to be designed to address each type of problem, some interventions will help to address all or most of the problems. These include changes in policies and processes as well as applications of information technology. The examples of strategies and specific tactics provided below are drawn from the experiences of Harvard Pilgrim Health Care.

Changes in Policies and Processes

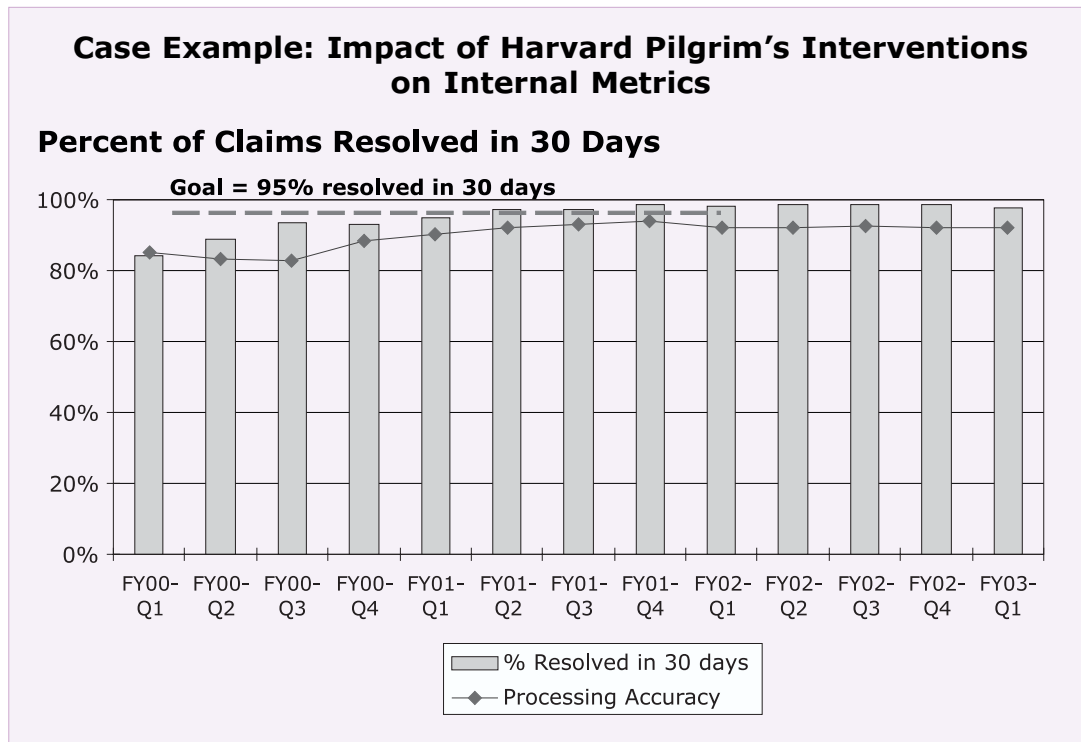
1. **Simplification of benefits and payment policies.** For example, the plan:
 - ⚡ Implemented contracting guardrails, which limit the customization of provider contracts to be configured in the claims system.
 - ⚡ Reduced reasons why a claim would pend to increase the percent of claims that can be auto-adjudicated.
 - ⚡ Implemented new processes that align Customer Service and Claims to allow claims submitted for reimbursement directly by the member to go through Claims correctly the first time, and for checks to be issued immediately after adjudication is complete.
 - ⚡ Implemented an in-line quality control program to identify and fix claim processing errors before processing is complete. Processors are held fully accountable for claim accuracy.
2. **Provider education around the most common types of problems.** For example, Harvard Pilgrim created a highly integrated Payment Policy Team to create, implement, and communicate the plan's payment policies. Prior to that, providers that submitted claims incorrectly had few tools to educate them on the plan's payment and billing policies. As a result of the Payment Policy Team's efforts, the plan released both a hospital provider manual as well as a major revision of a physician manual to aid providers with billing.
3. **Restructuring, training, and support tools for staff.** For example, the plan:
 - ⚡ Created a dedicated Provider Claims Focus Team to address specific provider issues and root cause analysis. This team increased analysis of second submissions and appeals to address the root cause of the top issues for re-submission.
 - ⚡ Standardized all Claims policies, procedures, and processing guidelines and placed them on an internal Web site. Processors were required to use the Web site as the "truth" copy of guidelines.
 - ⚡ Improved performance of the claims processing staff by:
 - Introducing training and cross-training initiatives to address quality control issues.
 - Restructuring teams to specialize in claim types, which helps with accuracy and other aspects of performance.

- Implemented a quality incentive program enabling staff to earn bonus dollars for meeting criteria for quality and productivity.
 - Implemented a formal quality control program including re-training and progressive disciplinary action for staff unable to maintain quality and productivity standards.
4. **Payment arrangements that do not depend on claims processing** (such as capitation).

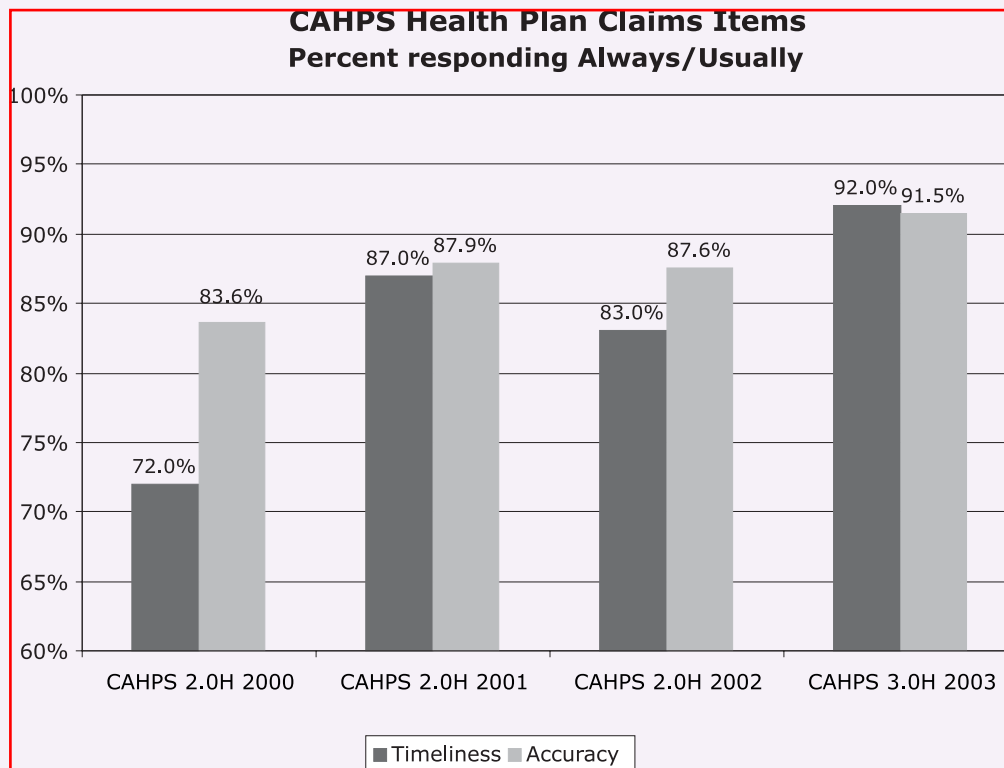
Applications of Information Technology

5. **Electronic data interchange for claims processing.** Harvard Pilgrim increased claims submission through EDI by participating in the New England Health EDI Network (NEHEN) and developing online Web-based claims submissions.
6. **Imaging system for paper claims.** This system manages inventory and assists the Provider Call Center in answering provider phone calls regarding submitted claims. This helped to reduce the number of claims that were re-submitted by providers and improved the efficiency of the Provider Call Center, enabling a quicker response to provider inquiries.
7. **Automated Phone/Online eligibility checking to prevent denial of services.** Harvard Pilgrim implemented automated tools for providers to check a member’s eligibility for services prior to delivery. This helped reduce the likelihood that members would receive services that were not covered without being informed of this in advance.
8. **Automated Phone/Online tools for providers and members to check on claim status.** At Harvard Pilgrim, these automated tools helped them quickly determine whether or not a ~~claims had been paid and why a claims was either pended or denied.~~

As a result of these interventions, Harvard Pilgrim saw improvements in both its internal metrics (percent of claims resolved in 30 days -- see below) as well as the pertinent CAHPS items (see box on the next page).



Case Example: Impact of Harvard Pilgrim's Interventions to Improve Claims Processing



Section 4-F

Improvement Strategies for “Home Health and Preventive Services”

In addition to the CAHPS composites, QI teams can also use responses to supplemental items in the CAHPS surveys to uncover specific problem areas that lend themselves to targeted quality improvement strategies. The Medicare CAHPS instrument, for example, asks respondents questions about their experiences with home health care services and preventive services and advice. These are listed in the table below.

Supplemental CAHPS Questions from the Medicare CAHPS Survey

Question about Home Health Care

- /// In the last 6 months, how much of a problem, if any, was it to get the (home health) care or assistance you needed through your Medicare health plan?

Questions about Preventive Services and Advice

- /// In the last 12 months, have you had a mammogram (a test to detect breast cancer in women)?
- /// In the last 12 months, have you had a pap smear (a test to detect cervical cancer in women)?
- /// In the last 12 months, have you had a prostate screening or PSA test (a test to detect prostate cancer in men)?
- /// In the past 4 weeks, how often have you walked and/or exercised for more than 20 minutes at a time?
- /// In the last...months, how often did your health plan handle your claims in a reasonable time?
- /// Did you get a flu shot last year, at any time from September to December 2000?
- /// Did you get that flu shot either through your Medicare health plan or from your personal doctor?
- /// Have you ever had a pneumonia shot?
This shot is usually given only once or twice in a person’s lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.

This section offers two strategies for improving performance in these areas:

1. Innovative Home Health Services
2. Reminder Systems for Preventive Services and Immunizations

F.1 Innovative Home Health Services

The Problem

CAHPS data can reveal to a health plan or provider network whether patients are experiencing problems with home health care services. In some cases, these problems occur because the current models for delivering home health care services do not meet the needs of those members.

Growing out of what originated as community health nursing in the early 1900's, home health traditionally takes place under three models:

- /// **Skilled nurse visits** may take place via Private Duty Nursing Services, Home Health Agency Services who also provide home health aid services, or Personal Care Assistant Services. These visits are conducted in the patients home by a Medicare-certified agency nurse. Nurses visit intermittently to assess their patient's health status and to provide health care education as well as hands-on nursing care. The service provided ranges from regular care where nurses provide daily assessments of health to more complex care where nurses provide long-term care to patients requiring interventions for life-threatening episodes of instability.
- /// **Home health aide visits** are conducted by certified staff employed by a Medicare- certified agency. Health aides provide personal hands-on care and are able to perform simple procedures, administer medications, and assist with patients' physical therapy exercises.
- /// **Personal care attendant services** provide assistance with activities of daily living. These include such tasks as helping with meals, personal finances, shopping, and household chores.

The main problem with these models is that caregivers are not necessarily available when the member needs attention, information, or assistance.

The Intervention

A recent innovation that helps to address this problem is **tele-home health care**, which was started by Kaiser Permanente in California in response to increasing demand for home health services in the mid-1990's. Tele-home health uses remote video technology in the home health care setting, which permits nurses and patients to interact in real time while also allowing home health care staff to assess a patient's physical status. Using telemedicine, staff can monitor patients' vital signs, provide follow-up care, track the patients' progress, and provide educational services.

Models of Telemedicine

Tele-home health is one of several applications of telemedicine. Others include the following (University of Virginia Health Systems 2003):

- /// **Telemedicine-Facilitated Clinical Consultations** facilitates patient consultation, remote diagnosis, and patient care in all clinical specialties.
- /// **Teleradiology** supports the transmission of diagnostic quality (DICOM) radiographic images with rapid interpretation.
- /// **Interactive distance learning programs** such as grand rounds, and other special conferences, are offered through videoconferencing technologies.
- /// **Patient education seminars** can be designed to meet the needs of patients in remote locations.

Consultations, educational programming and administrative conferences offered through a telemedicine program provide cost-effective and confidential medical services to virtually any location.

Tele-home health care offers the potential to improve patient satisfaction with care while improving clinical outcomes. Remote home health care can also reduce hospitalizations because patients can be cared for in the home. Home health care is most significant in improving access to health care staff for patients and family caregivers as the technology provides them with access to a home health care provider 24 hours a day (Johnston, Wheeler et al. 2000). From the plan’s perspective, it also offers the potential for cost savings when home-based care can ~~substitute for in-person visits.~~

The costs of implementing a tele-home health care program include direct costs for payroll, benefits, travel, and cell phone usage as well as additional costs for capital equipment (computers, etc.) and telecommunication charges (Johnston, Wheeler et al. 2000).

What We Know About the Impact of Home Health Care

Interventions that rely on communications and information technology have been shown to enhance social support and cognitive functioning; enhance learning efficiency; improve clinical decision-making and practice; reduce health services utilization; and lower health care costs among certain study groups (Eng 2001). Evaluations of tele-home health as a model of care found it to be effective and well-received by patients (Johnston, Wheeler et al. 2000).

Additionally, studies have found it capable of maintaining quality of care and to have a great potential for cost savings (Johnston, Wheeler et al. 2000).

However, most assessments of general tele-health interventions have been limited to small groups, have not involved the randomized selection necessary for a controlled trial, have had limited follow-up periods, or have investigated proprietary interventions that may or may not be replicable (Eng 2001).

Key Resources

Johnston B, Wheeler L, et al. Outcomes of the Kaiser Permanente Tele-Home Health Research Project. *Arch Fam Med*, 2000 9(1): 40-5.

IHealthbeat.com – Offers up-to-date news on efforts around the country to use technology to improve home health care.

March Networks. Home Telehealth Solutions Backgrounder. Available at <http://hth.marchnetworks.com/pdf/hthbackgrounder.pdf>.

Scott, RE. Home Telehealth Pilot Project: Independent Evaluation (Executive Summary). April 2002. Available at <http://hth.marchnetworks.com/pdf/HomeTeleHealthReportExecutiveSummary.pdf>. (More information about the evaluation of a pilot program in Atlantic Canada is available at http://hth.marchnetworks.com/atlantic_project.asp.)

F.2 Reminder Systems for Immunizations and Preventive Services

The Problem

Many patients do not receive important immunizations and other preventive services and advice because they do not know to see their clinical team for these services, they forget to make appointments, or they miss scheduled appointments. Studies have shown that the rate of missed appointments ranges from 19 percent to 52 percent (Macharia et al. 1992). Missed appointments result in discontinuity of care, reduce care opportunities for other patients, disrupt the patient-provider relationship, and add to health care costs.

The fact that immunization rates for adults (and children) are below optimal levels supports this finding. In 1997, 65% of adults over 65 had had the influenza vaccine and only 45% had been vaccinated against pneumonia (Szilagyi, Bordley et al. 2000). Two common reasons for missed vaccinations are forgetting appointments and in the case of children, parents not knowing their child's immunization schedule (Alemi, Alemagno et al. 1996).

The Intervention

Two useful strategies for tackling this problem are:

- /// Reminder Systems for Patients
- /// Reminder Systems for Clinicians

Reminder Systems for Patients

One way to tackle the inadequate delivery of preventive services is to institute reminder and recall systems for patients. Reminder systems notify patients a few days before their scheduled appointment, while recall systems contact patients who have missed appointments and encourage them to reschedule.

The benefits of reminder and recall systems include improved immunization rates, fewer missed appointments (no-shows), and more preventive care visits. The higher levels of preventive services are likely to reduce morbidity and mortality from preventable diseases. Also, as more patients come for their allotted appointments, the practice can increase its visit capacity and reduce its costs, particularly those associated with the inefficient use of clinician and staff time when slots are wasted.

Reminder systems have been in use for several decades, and except for the more sophisticated computerized phone reminder systems, are not complex either to initiate or to operate. Reminder and recall systems can work through a variety of mechanisms meant to prompt the patient, including phone calls (by clinic staff or by computer), letters, postcards, and email. While all types of reminder systems are effective, telephone reminders have been found to be most effective, but also the most expensive compared to postcard and letter reminders (Szilagyi, Bordley et al. 2000).

Systems to reduce no-shows employ some additional techniques, including:

- /// Reducing perceived barriers (e.g., providing transportation)
- /// Providing information (such as pamphlets or videos) on the importance of regular preventive and health maintenance visits (Macharia, Leon et al. 1992)

Reminder, Recall, and Outreach (RRO) programs are a more resource-intensive version of these systems and have been used effectively to improve immunization rates for hard to reach populations, such as inner-city minority children (Szilagyi, Bordley et al. 2000).

Barriers to implementation include cost and lack of information about the variety of systems (Szilagyi, Bordley et al. 2000). Costs for immunization reminder programs vary widely; for example, the cost per additional child vaccinated ranges from \$7 to \$63. Studies have found that a letter reminder system can cost \$10.50 per fully vaccinated child, whereas a comprehensive program of reminders and community outreach can cost \$63 per child per year, with an estimated cost effectiveness of \$316 per year per fully vaccinated child (Szilagyi, Bordley et al. 2000).

What We Know About the Impact of Patient Reminder Systems

Reminder and recall systems are effective at improving immunization rates in adults and children (Szilagyi, Bordley et al. 2000). They also reduce the no-show rate for preventive services. Increases to immunization rates ranged from 5 to 20 percent in intervention groups compared to control groups. Effectiveness was shown for adult pneumococcus, tetanus, and influenza vaccines and for childhood vaccines, including the influenza vaccine (Szilagyi, Bordley et al. 2000). While all types of reminder systems were effective, telephone reminders were the most effective.

A review of studies of appointment reminder systems also found that they resulted in improvements. The rates of kept appointments increased an average of:

- /// 40 percent for patient contracts,
- /// 120 percent for letters,
- /// 190 percent for phone calls and for orientation/information programs (e.g., videos and pamphlets), and
- /// 660 percent for phone reminders for psychosocial appointments (Macharia, Leon et al. 1992).

In a study comparing the effectiveness of different approaches to improve immunization and screening, patient reminder systems were the fifth most effective method with an average improvement of 150 percent compared to control groups (Stone, Morton et al. 2002). More effective were organizational change, provider reminders (see discussion below), patient financial incentives, and provider education. Less effective (but still more effective than no intervention) were patient education, provider financial incentives, and provider feedback.

Key Resources

See the following case studies from the NCQA's Quality Profiles (www.qualityprofile.org):

- /// Flu Shots for Older Adults: Collaborating to Reduce Missed Opportunities
- /// Flu Shots for Older Adults: Measuring the Effect of Specific Interventions
- /// Influenza Vaccination for Senior: Access and Awareness — Dedicated Flu Clinics and Member Outreach
- /// Influenza Vaccinations for Senior: Removing Financial and Geographic Barriers to Access

Reminder Systems for Physicians

While physicians generally agree with preventive measures and guidelines, there is substantial evidence that physician compliance with such preventive measures is well below optimal (Shea, DuMouchel et al. 1996). Since most patient encounters revolve around treating acute illnesses and alleviating symptoms, preventive measures are often overlooked. (Litzelman, Dittus et al. 1993) One way to improve compliance with such secondary tasks is to provide physicians with organized and processed data at key times (Litzelman, Dittus et al. 1993).

Among physician reminders, the most prominent is the concurrent report, which offers the benefit of timeliness – i.e., it provides information to a physician at a time when she can act on it (Murrey, Gottlieb et al. 1992). Such reports are commonly in the form of a computer-generated printout of suggested preventive procedures that is attached to the front of a patient's chart. A common computer reminder system reviews the records of patients coming for scheduled appointments and prints out the necessary procedures and tests in the "orders" section of the encounter form (Litzelman, Dittus et al. 1993).

Other concurrent formats include tagged notes, stickers in patient charts, and cards given to patients to help them prompt physicians (Balas, Weingarten et al. 2000). The type or location of the prompt does not seem to matter; that is, reminders at a variety of places in the medical chart (e.g., tagged progress note, computer monitor display) are equally as effective as a printout at the front of the patient medical record. All achieve 12 to 14 percent improvement (Balas, Weingarten et al. 2000).

Other categories of reminders include:

- /// Intervisit reminders (i.e., a reminder sent to the physician after a visit when something is overdue)
- /// Registry reminders (e.g., an intervisit reminder for a specific patient group, such as those with chronic condition) (Murrey, Gottlieb et al. 1992)

Prior to implementing physician reminder systems, the health care organization should address the following questions (Murrey, Gottlieb et al. 1992):

- /// Do the affected physicians believe that the services they are being reminded about are important?
- /// Do the physicians agree on the best approach to these issues?
- /// Do they agree on which steps of the process need the most support?
- /// Does the reminder system meet physicians' needs while also incorporating safeguards against process failures?

Failure to consider these questions is likely to undermine the success of the reminder system.

It is important to note that significant rates of non-compliance with preventive procedures may indicate that there are fundamental problems with the underlying systems, which should be addressed before reminder systems are attempted (Murrey, Gottlieb et al. 1992).

What We Know About the Impact of Physician Reminder Systems

There is strong evidence from meta-analytic studies that physician reminder systems for preventive care are effective at increasing preventive procedures (Shea, DuMouchel et al. 1996; Balas, Weingarten et al. 2000). Balas et al. reviewed 33 controlled studies and found that reminder systems led to an average improvement in six preventive procedures of 13 percent, ranging from 5.8 percent for Pap smear to 17.2 percent for pneumococcal vaccination. (The other four procedures were fecal occult blood test, mammogram, influenza vaccination, and tetanus vaccination.) Extrapolating these results nationwide, the researchers estimated that reminder systems could save 8,333 lives per year (Balas, Weingarten et al. 2000).

Shea et al. reviewed 16 randomized controlled trials and found, for six preventive practices, an overall 77 percent increase in procedures when computerized reminder systems were used (Shea, DuMouchel et al. 1996). Litzelman et al. found a 19 percent relative difference in physician compliance with reminders on three procedures when physicians were required to actively respond to a prompt by indicating the action taken, compared to a reminder that required no active response (Litzelman, Dittus et al. 1993).

Appendix A: Items in the CAHPS Reporting Composites and Ratings

These are the question items and responses for each of the five CAHPS consumer reporting questions composites. Although Claims Processing is not a composite, it is included in this list as part of Plan Administrative Services. The exact wording of the ratings questions is on the next page.

CAHPS Health Plan Survey Composites and Items

Domain: Access

Getting Needed Care

(Responses: A big problem, A small problem, Not a problem)

With the choices your (child's) health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

In the last...months, how much of a problem, if any, was it to get a referral to a specialist that you (your child) needed to see?

In the last...months, how much of a problem, if any, was it to get the care (for your child) you or a doctor believed necessary?

In the last...months, how much of a problem, if any, were delays in (your child's) health care while you waited for approval from your (child's) plan?

Getting Care Quickly

(Responses: Never, Sometimes, Usually, Always)

In the last...months, when you called during regular office hours, how often did you get the help or advice you needed (for your child)?

In the last...months, how often did you (your child) get an appointment for regular or routine health care as soon as you wanted?

In the last...months, when you (your child) needed care right away for an illness or injury, how often did you (your child) get care as soon as you wanted?

In the last...months, how often did you (your child) wait in the doctor's office or clinic more than 15 minutes past your appointment time to see the person you (your child) went to see?

Domain: Interpersonal Care

How Well Doctors Communicate

(Responses: Never, Sometimes, Usually, Always)

In the last...months, how often did your (child's) doctors or other health providers listen carefully to you?

In the last...months, how often did your (child's) doctors or other health providers explain things in a way you could understand?

In the last...months, how often did your (child's) doctors or other health providers show respect for what you had to say?

In the last...months, how often did doctors or other health providers spend enough time with you (your child)?

Courteous and Helpful Office Staff

In the last...months, how often did office staff at your (child's) doctor's office or clinic treat you (and your child) with courtesy and respect?

In the last...months, how often were office staff at your (child's) doctor's office or clinic as helpful as you thought they should be?

Domain: Plan Administrative Services

Customer Service

(Responses: A big problem, A small problem, Not a problem)

In the last...months, how much of a problem, if any, was it to find or understand information in the written materials?

In the last...months, how much of a problem, if any, was it to get the help you needed when you called your (child's) health plan's customer service?

In the last...months, how much of a problem, if any, did you have with paperwork for your (child's) health plan?

Complaints (from CAHPS 3.0H – HEDIS Supplemental Items)

Of those who called or wrote their health plan with a complaint or problem: How long did it take for your health plan to resolve your complaint? (Responses: Same day, 2-21 or more days, Still waiting)

Of those whose complaint or problem was resolved: Was your complaint or problem settled to your satisfaction? (Responses: Yes, No)

Claims Processing (from CAHPS 3.0H – HEDIS Supplemental Items)

(Responses: Never, Sometimes, Usually, Always)

In the last...months, how often did your health plan handle your claims in a reasonable time?

In the last...months, how often did your health plan handle your claims correctly?

In the last...months, before you went for care, how often did your health plan make it clear how much you would have to pay?

Consumer Rating Items

Rating of Personal Doctors

Use any number on a scale from 0 to 10 where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible. How would you rate your (child's) personal doctor or nurse now?

Rating of Specialists

Use any number on a scale from 0 to 10 where 0 is the worst specialist possible, and 10 is the best specialist possible. How would you rate your (child's) specialist?

Rating of Health Care

Use any number on a scale from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all your (child's) health care?

Rating of Health Plan

Use any number on a scale from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate your (child's) health plan now?

Appendix B: Correlations Between Responses to CAHPS Items and Overall Ratings for Medicare Managed Care Respondents

Like Table 4 in Section 2, this table is based on data from the 1999 Medicare managed care CAHPS Health Plan Survey. It shows how individual CAHPS items correlate with ratings of care, doctors, and plans. The shaded boxes have correlation coefficients of 0.45 or higher.

Composites	Items	Doctor Rating	Care Rating	Plan Rating
Getting Needed Care	Happy with choice of doctor	0.37	0.42	0.38
	Problem seeing needed, appropriate specialist	0.19	0.31	0.27
	Problem getting necessary care	0.24	0.37	0.28
	Delays in health care while awaiting approval from health plan	0.17	0.30	0.33
Getting Care Quickly	Getting needed advice in a timely manner by telephone	0.39	0.49	0.34
	Routine appointments as soon as wanted	0.28	0.39	0.27
	Care for illness as soon as wanted	0.32	0.47	0.33
	Waited more than 15 minutes past appointment time	0.19	0.28	0.21
Getting Care	Difficulty getting care when needed	0.15	0.24	0.30
Health Plan Information and Customer Service	Problems understanding written health plan materials	0.14	0.25	0.43
	Problems getting customer service by telephone	0.15	0.26	0.54
	Problems with health plan paperwork	0.14	0.25	0.56

Composites	Items	Doctor Rating	Care Rating	Plan Rating
Customer Service Helpful	How often has customer service of health plan been helpful?	0.19	0.32	0.59
Courtesy and Respect of Doctor's Office Staff	Frequency treated with respect by medical staff	0.27	0.39	0.25
	Frequency of helpfulness from medical staff	0.34	0.48	0.32
Communication with Providers	Frequency with which health care providers listen carefully to patients	0.46	0.58	0.34
	Frequency with which health care providers explain things in an understandable way	0.41	0.54	0.32
	Frequency with which health care providers show respect to what patient has to say	0.43	0.57	0.34
	Frequency with which health care providers spend enough time with patient	0.44	0.59	0.34
Getting Special Services through the Health Plan	Difficulty getting special medical equipment through health plan	0.18	0.29	0.37
	Difficulty getting special therapy needed through health plan	0.22	0.36	0.43
	Difficulty getting care or home health care through health plan	0.23	0.34	0.45

* The plan-level composites listed here (and in Table 4) are different than the reporting composites for the CAHPS Health Plan Survey because the analyses are based on associations between plan scores, in contrast to analyses that examine relationships among responses by the same individual.

Source: 1999 Medicare Managed Care CAHPS survey data

Appendix C:
Peace
Health’s
Shared Care
Plan

Whatcom County/Peace Health, For more information, please contact HWilson@peacehealth.org,

Below is important information for all members of the care team. ☒ Please complete with a member of your care team.

My name:		My phone:	Today’s date:
Birth date:		My email address:	
Family contact and phone:			
Person providing information for care and care plan (parent, guardian, or other patient representative):			

I want the person working with me to know...

I have challenges with: <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> English as a second language (ESL) <input type="checkbox"/> Other	
Comments:	
I have issues with Diet: <input type="checkbox"/> YES <input type="checkbox"/> NO Comments:	
My Religion/Spirituality impacts my health care: <input type="checkbox"/> YES <input type="checkbox"/> NO Comments:	
I have: Advanced Directives <input type="checkbox"/> YES <input type="checkbox"/> NO Physician Orders for Life Sustaining Treatment (POLST) <input type="checkbox"/> YES <input type="checkbox"/> NO Power of Attorney <input type="checkbox"/> YES <input type="checkbox"/> NO Comments:	
I live: <input type="checkbox"/> alone <input type="checkbox"/> partner/spouse <input type="checkbox"/> extended family <input type="checkbox"/> Other:	
I learn best by: <input type="checkbox"/> reading <input type="checkbox"/> being talked to <input type="checkbox"/> having someone show me how <input type="checkbox"/> listening to tapes <input type="checkbox"/> seeing pictures or video	
I have access to the Internet <input type="checkbox"/> YES <input type="checkbox"/> NO	

My Care Team				
Next appointment	Name	Initial	Phone / Fax	Role
				Caregiver/Support
				Clinical Care Specialist
				Primary Care Doctor
				Cardiologist
				Endocrinologist
				Pharmacist
I authorize my shared care plan to be shared with my Care Team listed above: <input type="checkbox"/> YES <input type="checkbox"/> NO				
Others with whom I agree to view my plan include:				

Diagnoses	
(add rows as needed)	

My Medication Profile		
Drug Allergies / Intolerances	Reaction	Date Occurred
		Comments

(add rows as needed)			
Other Allergies:			

Over-the-counter Meds				
Name	Directions	Times Taken	Why Taken	Comments
Aspirin				
(add rows as needed)				

Prescription Meds									
Date	Rx by	Drug Name	Directions	Use	B 8-9	L 12-1	D 6-8	Bed 9-11	Additional Comments
				ACE Inhibitor					
				Beta Blocker					
(add rows as needed)									

Discontinued Meds							
Date	Rx by	Drug Name	Directions	Use	B 8-9	L 12-1	D 6-8
		0					
(add rows as needed)		0					

I am worried about: ☐ my ability to manage my chronic condition ☐ financial issues ☐ access to healthcare

☐ emotional issues ☐ family issues ☐ spiritual support ☐ thinking or memory problems ☐ end of life issues

☐ Other:

My long term goal:

HgA1c goal: Most Recent HbA1C:

Current EF: %

Next steps to wellness:

(Completed by patient and other members of Care Team. Each step can be initiated by patient or other member of Care Team. Steps may include concerns about medical condition, problems, barriers, or goals and are followed by actions, solutions, observations, the current status of the step, etc. Group entries about each topic together.)

Date	Concerns / Problems / Actions / Comments / Status	By

Next steps to wellness:	
(add rows as needed)	

Health Logs
(i.e., exercise, blood sugar testing, low-salt eating plan, daily weight, lab results, stress reduction, medication management)

Example:

HbA1c (Normal range = 4.0-6.0)	
8/26/02	6.7
3/4/02	8.6 Recovering from broken leg
6/26/01	6.6
(add rows as needed)	

(Other concerns)

Appendix D: Variations of the Group Visit Approach

	Cooperative Health Care Clinic	Drop-In Group Medical Appointment (DIGMA)	Continuing Care Clinic	Cluster Visits for Diabetes Care	Chronic Disease Self-Management Program (CDSMP)	Support Groups
Patients	Elderly with one or more outpatient visits/month	Either mixed group or single diagnosis	Elderly with chronic condition OR diabetes on medication	Age 16-75 with HbA1c > 8.5 % or none for 1 year	Ages 40 and up with heart disease, lung disease, stroke, or arthritis.	Widely used in all ages and many conditions for patients and/or caregivers.
Setting	HMO (Kaiser Colorado)	HMO (Kaiser Southern California)	HMO (Group Health Cooperative of Puget Sound)	HMO (Kaiser Northern California)	Community-based, (Churches, senior centers) or clinic	Community or Clinic based
Interval	Monthly group meetings of 25 patients	Set by provider team, depending on format. Weekly or monthly.	3 or 4 times/yr., 8 patients	monthly visits for 6 months with 10-18 patients	Seven weekly class sessions, 10-16 participants (revised version is six sessions)	Varies. Monthly is a typical interval. Most groups function well with between 8 and 20 members.
Staffing	Primary Care Provider RN Occas. Ancillary staff (pharmacy, PT, dietician)	Primary Care Provider, Medical assistant, Psychologist (some sites using SW or RN)	Primary Care Provider RN Pharmacist SW or RN for group	Diabetes nurse educator In consultation or by referral: podiatrist, pharmacist, psychologist, nutritionist, pharmacist, primary care provider	Two volunteer lay leaders per course	Varies from peer led to professionally led. MSG= Mutual Support Group.
Schedule	15 min. warm-up 30 min presentation 15 min "break" (providers circulate and triage) 15 min. Q&A 30 min allotted for brief 1:1 with MD	90 minutes total. MA does vitals, chart retrieval, Psychologist warm-up until provider arrives Interview patients in room sequentially, provider does some "huddle" conversations with	½ day clinic with 45 minute group session in the middle. Patients spend 15 minutes each with pharmacist, MD, and RN either before or after the group.	Two hour visit based on evidence-based protocol Between-visit proactive phone calling Individual visits as needed (30% of patients used). Regular case review by primary care provider.	Each session is 2 ½ hours long, which includes a lengthy break. Sessions are interactive using return demonstration, modeling, brainstorming and problem solving. Telephone calls to	Varies. Groups are typically considered either social support or educational with support. Some include cognitive behavioral techniques (CBT).

	Cooperative Health Care Clinic	Drop-In Group Medical Appointment (DIGMA)	Continuing Care Clinic	Cluster Visits for Diabetes Care	Chronic Disease Self-Management Program (CDSMP)	Support Groups
Topics	Six topics determined by provider (evidence-based clinical priorities, such as immunizations, advanced directives), six topics determined by group.	Determined by attendees medical issues. Psychologist emphasizing commonalities, self-care, coping as much as possible.	Planned visit following evidence-based clinical priorities for geriatrics or diabetes. Group focused on self-management support.	Risk factor reduction, Self-management, Skills teaching (monitoring, insulin use) By patient request: exercise, sexual dysfunction, stress management, emotional concerns	encourage action plans by lay leaders, then between group members. Topics include exercise, cognitive sx mgmt techniques, nutrition, fatigue and sleep mgmt, use of comm. resources, use of meds, dealing with emotions, communicating with others, problem-solving, decision-making	Some offer no structure, some are highly structured.
Results	RCT and implementation data: decr. ER visits decr. Specialist visits decr. Hospital admits incr. nurse visits and nurse calls decr. Calls to MD decr. Cost \$14,79 PMPM	Anecdotal and non-comparison: impr. Patient satisfaction impr. Access impr. Provider satisfaction	RCT: Elderly: incr. Satisfaction no change in clinical outcomes. Diabetes: incr. Preventive services incr. Satisfaction with diabetes care incr. Primary care visits but decr. specialty and ER visits improved outcomes with incr. attendance, incl.	RCT: Decr. HbA1c by 1.3% Improved self-efficacy Incr. self-care practices Impr. satisfaction Lower hospital and outpatient utilization	RCT: Increased exercise Increased cognitive symptom management Improved self-reported health Longitudinal follow-up: Reduced ER/outpatient visits Reduced health distress Improved self-efficacy	Multiple RCT's: Decreased symptoms in depression for groups with both CBT or MSG, but CBT improved more. (Bright, 1999). Indications that telephone groups work as well as on-site groups in caregivers of head-injured pts (Brown, 1999). Education or education and peer support were

	Cooperative Health Care Clinic	Drop-In Group Medical Appointment (DIGMA)	Continuing Care Clinic	Cluster Visits for Diabetes Care	Chronic Disease Self-Management Program (CDSMP)	Support Groups
			HbA1c.			superior to peer support alone in breast CA (Helgeson, 1999) CBT superior to MSG in IBS (Payne, 1995)
Citation	Beck et al.; JAGS 45:543-549, 1997. Coleman et al, Eff Clin Prac 4(2):49-57, 2002. Adaptation: Masley et al, FPM June 2000	Noffsinger E. Grp Prac Jrnl 1999;48(issues 1, 2, 3, 4, 6) Noffsinger E. The Permanente Jrnl 1999;3(3):58-67.	Coleman et al, JAGS 47:775-783, 1999 Wagner et al, Diabetes Care 24:695-700, 2001.	Sadur et al, Diabetes Care, 22(12):2011-2017, 1999.	Lorig et al. Medical Care 37:5-14, 1999. Lorig et al. Medical Care 39:1217-1223, 2001.	See above. Search terms self-help group and support group.
Guide available	Yes On ICIC website Contact John Scott, MD at Kaiser Colorado 303-657-6808 FPM: http://www.aafp.org/fpm/20000600/33plan.html	Unknown	Yes On ICIC website contact Connie Davis at GHC, 206-287-2554 or davis.cl@ghc.org	Unknown	Manual for leaders, book for participants (Lorig et al, Living a Healthy Life with Chronic Conditions, Bull Publishing, 1997.)	Some voluntary organizations have materials, such as the American Stroke Association.
Information on use in other settings	Dr. Scott had HCFA review their model and HCFA has stated that this is a billable MD visit. FPM article describes coding for appropriate reimbursement, typically 99212, 3, or 4.	Some now calling "Doctor interactive group medical appointments." Currently being studied in clinical trial.	Widely used in Britain as a "mini clinic."	Anecdotally, many sites using this approach.	Adapted from Arthritis Self-Help Course. Also used in low back pain, HIV/AIDS, diabetes. More information at http://www.stanford.edu/group/perc/cdsmp.html	No reimbursement available.

Source: Connie Davis, Improving Chronic Illness Care Program.

Appendix E: How to Conduct A Walk-Through

A walk-through is your opportunity to experience what patients and family members experience when they receive care at your organization. For example, if you are examining the emergency room, choose a particular type of patient (e.g., one with asthma). You and another team member would then present to the emergency department as a patient with that disease and the patient's family member. Here are some tips on how to conduct a successful walk-through:

1. Let the staff know in advance that you will be doing this walk-through.

As a result of this warning, they will probably be on their best behavior. However, experience suggests that it is far better to have them part of the process than to go behind their backs. Ask them not to give you special treatment.

2. Go through the experience just as the patient and family member would.

Call in advance, if the patient would have to. Drive to the emergency department, drop the patient off, find a place to park, and check in. Try to act as if you have never been there before. Follow the signs. Tell the clerk that you are simulating a patient's experience and that you want to go through whatever a normal patient would have to do (e.g., the check-in process). Actually fill out the forms if there are ones to fill out. Find out how long a patient would typically wait and sit in the waiting room for that amount of time. Wait your turn. Do the same in the examining room. If the patient undresses, you should undress. If the patient does a peak flow meter, you should too. Ask each health care provider to treat you as if you were a real patient. If you are doing a walk-through of the cardiac cath service, hold the sandbags on your leg the required amount of time. Experience it all.

3. As you go through the process, try to put yourself in the patient's (or family member's) position.

Look around as they might. What are they thinking? How do they feel at this moment?

4. At each step, ask the staff to tell you what changes (other than hiring new staff) would make the experience better for the patient and what would make it better for the staff. As you do the walk-through, think about how you would answer the following questions and ask the staff you interact with to answer them when you can:

- /// What made you mad today?
- /// What took too long?
- /// What caused complaints today?
- /// What cost too much?
- /// What was wasted?
- /// What was too complicated?
- /// What involved too many people or too many steps?
- /// What did you have to do that was just plain silly?

Write down their ideas as well as your ideas. But also write down your feelings.

5. Finally, between the two of you (patient and family member), write down a list of what needs you found and what improvements could be made. Keep track of the things that can be fixed the next day versus problems that will take longer to remedy.

Appendix F: The Axioms of Service Recovery

When problems with service do occur – and they will – your organization has to be prepared with a service recovery program that is designed to turn a disgruntled patient or member into a happy, loyal one. (To learn more about this strategy, see *Idea D.3: Service Recovery Programs*.) Based on previous work in this area, researchers have developed what they term the “axioms of service recovery.” (Zemke and Bell 2000) The more your staff understand these axioms, the easier it will be for them to respond effortlessly and appropriately to service problems when they arise.

Axiom 1. All customers have basic expectations.

Researchers have found that these five categories of customer expectations account for 80 percent of the differences between high and low customer satisfaction (Berry, Zeithaml et al. 1990).

These factors are as follows:

- ✦ Reliability is the most important of the five. It signals organizational competence and promotes confidence and trust in the organization or clinician.
- ✦ Assurance involves reassurance that everything is going as it should or, if it isn't, that something will be done to remedy the problem quickly.
- ✦ Tangibles are the visible, concrete signs that influence the other expectations. When the furnace repair person shows up with dirty hands, no one is surprised. When the doctor walks in the room with a filthy white coat and dirty hands, something else is communicated quickly and convincingly to the patient. Old magazines in the waiting room, dirty bathrooms, and chaotic registration areas all imply an organization that is not under control.
- ✦ Empathy conveys that you are listening and concerned about the experiences and care of your members and patients. When something happens to disrupt trust, reconnecting with the patient or member in a personal way that conveys you understand is critical to the service recovery process.
- ✦ Responsiveness refers to the expectation that things should happen in a timely fashion and that people should be kept informed about where they are in the process. The opposite of responsiveness is indifference and lack of communication. Solutions to problems need to be timely and responsive to the person's need.

Axiom 2. Successful recovery is psychological as well as physical.

Perhaps the most important step in the recovery process is listening to the person and letting them vent their frustration and blow off steam. Letting the person tell their story and describe the impact of the failure is essential.

Axiom 3. Work in a spirit of partnership.

Involve the person in helping to solve the problem. However, this does not mean that the first question should be, “So what do you want me to do about it?”. Work cooperatively to come up with a solution that makes the person feel like part of the problem solving and that acknowledges their needs.

Axiom 4. Customers react more strongly to "fairness mistakes" than to "honest mistakes."

Research on service recovery indicates that the only effective solution when a person feels like they have been unfairly treated is extreme apology and atonement. When a situation like this occurs, the patient or member is a prime candidate for overt retaliation (Seiders and Berry 1990). Communication about what went wrong and compensation or atonement are essential in these situations. From the patient safety movement, we know that a critical component of resolution in these kinds of situations is letting the person know you and your organization will make sure this never happens to the patient or *anyone else again*.

Axiom 5. Effective recovery is a planned process.

In health care, certain problems are highly predictable. Surgeons get delayed in the operating room, flu season packs the appointment schedule, implementing a new call center system inevitably causes service glitches – but we often act like these problems are a surprise.

Preparing your staff with solutions for predictable problems and teaching them how to offer and implement these solutions is essential. Even though you may have planned solutions in place, they must be offered in a very customer-sensitive way so that you do not leave people with the impression that the problem is common or your staff behave like robots.

Research on the top ten service issues for bank customers is equally applicable to patients and health plan members. These are examples of situations that call for a planned solution in the event of a service breakdown and could be used as the framework for similar events in a health care setting.

Think about how you could translate these principles into planned protocols for the common problems your patients and members experience.

Top Ten Service Expectations of Retail Bank Customers

1. Being called back when promised.
2. Receiving an explanation of how a problem happened.
3. Knowing who to contact with a problem.
4. Being contacted promptly when a problem is resolved.
5. Being allowed to talk to someone in authority.
6. Being told how long it will take to resolve a problem.
7. Being given useful alternatives if a problem cannot be resolved.
8. Being treated like a person, not an account number.
9. Being told about ways to prevent future problems.
10. Being given progress reports if a problem cannot be solved immediately.

Source: Zemke R, Bell C. *Knock Your Socks off Service Recovery*. New York, NY: American Management Association, 2000.

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